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Supreme Court, U.S.
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No. _____

In The

Supreme Court of the United States

SHIRLEY A. GRAHAM,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY

Respondent.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. In an action for plan benefits under ERISA, 29 U.S.C. § 1132(a)(1)(B), is a District Court's Order remanding the matter back to the Plan Administrator for a fair determination a final appealable decision under 29 U.S.C. § 1291 when the basis for the remand is that the decision to deny benefits was arbitrary and capricious and not supported by substantial evidence?

PARTIES

The Petitioner is Shirley A. Graham ("Graham").

The Respondent is Hartford Life & Accident Insurance Company ("Hartford")

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PETITION FOR A WRIT OF CERTIORARI

Graham respectfully submits that a writ of certiorari should issue to review the judgment of the Court of Appeals, Tenth Circuit.

OPINIONS BELOW

The opinion of the United States Court of Appeals is found at 501 F.3d 1153 and reprinted in the Appendix ("App.") at Page 1a. The opinion of the lower court is found at 2007 WL 160309.

JURISDICTION

The United States Court of Appeal's Order and Judgment was filed on August 24, 2007. This petition is being timely filed within 90 days of that date. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the following statutes: 28 U.S.C. § 1291 and 29 U.S.C. § 1132 set forth at App. 23a to 32a.

STATEMENT OF THE CASE

A. INTRODUCTION

This case was originally filed in the United States District Court for the Northern District of Oklahoma under state court causes of action of breach of an insurance contract and insurance bad faith. The reason a state court cause of action was brought originally rather than an ERISA action is that the Plaintiff was a rural letter carrier with the United States Postal Service ("USPS") and had obtained her disability insurance through her union, the National Rural Letter Carriers Association ("NRLCA"), the Collective Bargaining Union for rural letter carriers. Membership in the Union and eligibility for the subject insurance required a person to be employed by the USPS and work in the rural carrier craft. Excluded from membership are temporary relief carriers. Further, the Plan provided that the premiums should be deducted from the rural letter carrier's U.S. Postal Service's wages. On April 22, 2005, more than two (2) years after the suit was filed, Senior United States District Court Judge James O. Ellison entered an Interlocutory Order determining the disability insurance Plan in question was subject to ERISA jurisprudence and that the Plan in question was not a governmental plan. Because this Order was interlocutory in nature, an appeal from that particular Order could not be taken but had to wait until the matter was fully resolved.

The action then proceeded as a normal ERISA action where the parties submitted an Administrative Record and then a briefing schedule was followed. The Court took the case under advisement and on January 20, 2006, United States District Judge Claire V. Eagan entered an Order finding that the Defendant failed to establish by substantial evidence that its denial was reasonable and concluding that the denial of benefits was arbitrary and capricious under the appropriate standard. However, rather than reinstating the benefits, the Trial Court ordered that the matter be remanded to the Plan Administrator "for a full and fair redetermination of the claim".

Graham appealed from the two (2) decisions. The first being whether or not ERISA applied to the matter at all and second, if ERISA applied, was a remand to the Plan Administrator an appropriate remedy.

Graham then filed for attorney fees which were denied and a second appeal was perfected on that issue.

The matters were consolidated and subsequently the United States Court of Appeals for the Tenth Circuit entered an Order stating that it did not have jurisdiction because the Order remanding was not a final appealable Order under 28 U.S.C. § 1291. Thus, almost seven (7) years after Graham left her job with the United States Post Office, and more

than four (4) years after she initiated this suit, she is no closer to obtaining her benefits than she was when she left her job on July 17, 2000, or when the United States Office of Personnel Management approved her for disability retirement less than six (6) months later, on December 1, 2000.

As will be discussed in more detail, the finding of the Trial Court that the denial of benefits was arbitrary and capricious was based upon the Court's conclusion that there was not substantial evidence to support the denial and, thus, the denial was arbitrary and capricious. At no time in the proceedings did Plaintiff allege any procedural defect in the administrative process. The record will reflect that the matter was fully addressed at the administrative level with two levels of appeal addressing the initial denial.

Nor did the Defendant Hartford ever request a remand but always asserted that its denial of benefits was supported by substantial evidence and was not arbitrary and capricious.

The temptation at this point is to argue that remanding a case such as this back to the Plan Administrator for a fair determination after the matter has been fully evaluated three times before in the administrative process is just one more obstacle that keeps deserving beneficiaries from receiving the benefits they are entitled to in a timely manner, if at all. If possible, this new wrinkle could be even

more offensive than the other impediments that beneficiaries face, like denial of right to trial by jury, inability to confront the witnesses against them, inability to conduct discovery, deference given to the decision by an insurance company to deny benefits and the lack of any compensatory or punitive damages. All of these are offensive to the rights of beneficiaries to receive their benefits, hinder beneficiaries' rights to receive a full, fair and complete adjudication of their claims, and most definitely encourages insurance companies and self-funded Plans to deny benefits on the skimpiest of reasons. As we will note, this case is a classic example.

Although the denial of right to trial by jury offends our United States Constitution and, in particular, the seventh guarantee found in the Bill of Rights and lack of any compensatory or punitive damages seems to offends this legislation's stated intent and savings clause, the frustration that we now address may be the most offensive of all. The reason for this is that it seems to reward wrong doing. Obviously, from a practical standpoint, an insurer such as Hartford is benefitted when they avoid or defer payment of benefits under the terms of a disability contract.

In the case at bar, the Trial Court concluded that the denial of benefits was not supported by substantial evidence and, thus, the denial was arbitrary and capricious. Hartford could not even

muster enough evidence to support its denial under the deferential arbitrary and capricious standard where all they had to do was have evidence that is more than a scintilla but less than a preponderance. As this Court reviews this Petition for Certiorari, it will be more than seven (7) years since Shirley Graham first submitted her claim to Hartford and she is no closer to getting her benefits than she was in November 2000. As this Court considers whether or not it should grant certiorari, it will be close to five (5) years since the Plaintiff filed her initial Complaint at the District Court level and yet she is even farther away from getting an adjudication on her rights to receive these benefits than she was when she first filed that Complaint.

Moreover, Graham may never be entitled to a judicial determination of whether or not ERISA jurisprudence even applies to this situation or should her attorney be entitled to an attorney fee for "successfully" carrying her burden and proving that the denial of her initial claim was arbitrary and capricious. These would seem to be compelling reasons for this Court to take this matter up.

However, equally as important and probably more compelling to this Court is the fact that there is a division among the Circuit Courts of Appeal regarding when an ERISA remand order is a final appealable order and when remand to a Plan Administrator would be appropriate. In a Tenth Circuit case that preceded the present case and one

that was relied on by both parties before the Tenth Circuit, the Tenth Circuit Court of Appeals concluded "that district court orders remanding an issue to an ERISA plan administrator are not *per se* nonfinal. The decision should be made on a case-by-case basis applying well-settled principles governing final decisions.'" *Rekstad v. First Bank System, Inc.* 238 F.3d 1259, At 1263 (10th Cir. 2001).

We will see that the different Circuits disagree as to what well-settled principles regarding finality apply to an ERISA remand to the Plan Administrator and when it is appropriate to remand a case to a Plan Administrator. The Ninth Circuit has stated, "A plan administrator will not get a second bite at the apple when its first decision was simply contrary to the facts." *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, at 1163 (C.A. 9 2001). That appears to be precisely what happened in the case at bar. We will see that there is overwhelming evidence of Shirley Graham's disability in this administrative record. The denial was based on the jaundiced review of the administrative record by Hartford and its obvious cherry picking of the record to muster more than a scintilla of evidence to support its denial. Despite this attempt and the deferential review given the denial, it was determined to be arbitrary and capricious.

As we will see, there was a full and complete medical history of Shirley Graham's condition

chronicling its onset in February of 1994 and going through August 2002. This eight (8) year medical history bookends the December 1, 2000, decision by the United States Office of Personnel Management approving Shirley Graham for disability retirement. There was the initial investigation and denial and two levels of administrative review. The Order remanding the matter back to the Plan Administrator for a fair determination of Graham's entitlement to disability benefits did not find any procedural defect and, as stated earlier, none was asserted either by the Plaintiff Graham nor by the Defendant Hartford. Given the *Rekstad v. First Bank System, Inc., supra*, decision and the decision before this Court, it is hard to imagine what kind of case the Tenth Circuit would find appropriate for appellate review. This becomes particularly confusing when you see the expressions of other Circuit Courts of Appeal For these reasons as will be set out in more detail, Graham urges this Court to grant her Petition for Certiorari to the Tenth Circuit Court of Appeals ordering the Court to accept jurisdiction and decide the issues presented to the Court of Appeals.

B. FACTUAL BACKGROUND

Graham is not asking this Court to decide the issues it presented to the Tenth Circuit Court of Appeals regarding whether the subject Plan is a government Plan and, thus, not subject to ERISA preemption, whether Graham is entitled to disability

benefits under the Administrative Record and entitlement to attorney fees. However, it is felt that the factual underpinnings of these arguments are important to this Court's decision whether to grant certiorari. In the first section, we will review some of the facts that were presented to the Tenth Circuit on the issue of the status of the Plan as a government Plan and in the next section, we will set out the exact abstract of the Administrative Record that was initially presented to the Tenth Circuit Court of Appeals in our Brief In Chief. We feel that it is particularly important to do this second section as completely as we can as these facts would go to the propriety of remanding this matter back to the Plan Administrator and the jurisdiction of the Tenth Circuit to review that Order.

> "We must first consider whether we have jurisdiction. Circuit Courts generally have jurisdiction only over "final decisions of the district courts." 28 U.S.C. § 1291; cf. id. § 1292 (describing circuit courts' jurisdiction over interlocutory decisions). In *Rekstad v. First Bank System, Inc.*, 238 F.3d 1259, 1263 (10th Cir.2001), we held that a district-court order remanding a case to an ERISA plan administrator for a determination of LTD benefits was not a final appealable decision over which we had jurisdiction. Accord *Graham v. Hartford Life & Accident Ins. Co.*, Nos. 06-5054 & 06-5142, 2007 WL 2405264 (10th Cir. Aug.24, 2007) (**dismissing for**

lack of jurisdiction when the district court had concluded that substantial evidence did not support a denial of benefits and remanded the claim to the plan for redetermination)." *Garner v. U.S. West Disability Plan* 2007 WL 2989460, ___F3d___(10th Cir. 2007) (emphasis added).

C. TRIAL COURT PROCEEDINGS

Graham filed her Complaint on February 27, 2003, alleging state court causes of action for breach of an insurance contract and Oklahoma insurance bad faith. Graham alleged that jurisdiction was with the Federal Court because of diversity.

Hartford answered alleging that ERISA applied to this matter and at a Scheduling Conference held on April 15, 2004, Senior Judge James O. Ellison entered a discovery and briefing schedule to address the issue of the application of ERISA to the case. The briefing on that issue was completed on August 17, 2004, and on April 22, 2005, Judge Ellison entered an Order determining that the subject Plan was not a government Plan and that ERISA applied. Subsequently, the Administrative Record was submitted to the Court, the parties briefed the issue of entitlement to benefits and on January 20, 2006, Judge Claire V. Eagan entered her Order that the Defendant's final decision to deny Plaintiff's claim for LTD benefits was not supported by substantial evidence, was arbitrary and capricious and

remanded the case back to the Plan Administrator for a full and fair redetermination of the claim. On that same date, Judge Eagan entered a Judgment remanding the case to the Plan Administrator, dismissing/terminating the case (terminates case).

After the Court's decision finding the denial arbitrary and capricious, Graham filed an Application for Attorney Fees pursuant to 29 U.S.C. § 1132(g)(1). The attorney fee application was timely filed and was referred to the Magistrate for a Report and Recommendation. Magistrate Judge Sam A. Joyner entered a Report and Recommendation to deny the attorney fees and a timely objection to that Report and Recommendation was filed. On June 28, 2006, United States District Court Claire V. Eagan overruled the Plaintiff's objection to the Report and Recommendation.

D. APPELLATE PROCEEDINGS

Graham initially appealed the Interlocutory Order finding that the Plan was not a government Plan and, thus, subject to ERISA, as well as the Order remanding the case to the Plan Administrator under Appeal Case No. 06-5054. Later a second appeal was perfected under Case No. 06-5142 on the issue of entitlement to attorney fees.

In Case No. 06-5054, the Plaintiff filed her Initial Brief and then the Defendant Hartford filed its

Response Brief. By virtue of the allegation in the Response Brief filed by Hartford that the January 20, 2006, Order and separate Judgment did not constitute a final appealable decision under 28 U.S.C. § 1291, the United States Court of Appeals for the Tenth Circuit entered an Order on June 1, 2006, tolling the briefing on the merits and directing Graham to file a separate jurisdictional memorandum brief within twenty-one (21) days of that Order. On August 14, 2006, the Appellate Court entered an Order reserving judgment on the Appellate jurisdictional issue of finality raised by Hartford and ordered that the jurisdictional issue be submitted to the panel selected to handle the appeal. Of course, further granting Graham the opportunity to file a Reply Brief within fourteen (14) days of that Order.

The Tenth Circuit denied an Application to Consolidate the two (2) appeals but did subsequently consolidate the two (2) appeals for oral argument which was held on March 5, 2007. On August 24, 2007, the Court filed its opinion that there was no appellate jurisdiction.

REASONS THE PETITION SHOULD BE GRANTED

1. THERE IS A DIVISION AMONG THE CIRCUITS REGARDING THE FINALITY OF A RULING SUCH AS THE ONE BEFORE THIS COURT

We have set out the extensive abstract of the Administrative Record above because we feel it is important for this Court to understand the basis of the Trial Court's ruling and why we believe a ruling such as this should be considered a final, appealable order. It is clear from the Tenth Circuit Court of Appeals' Opinion, as well as the Trial Court's Opinion, that the finding that the denial of benefits was arbitrary and capricious and not supported by substantial evidence went to the merits of the claim rather than some sort of procedural defect. In finding the denial arbitrary and capricious, the Trial Court made the following observations regarding the Administrative Record:

> "The Court finds that Hartford's decision to deny plaintiff's claim for LTD benefits was arbitrary and capricious. Hartford has not met its burden of proving the reasonableness of its decision by substantial evidence. Hartford referenced, as the basis for its determination, the 1997 accommodation for plaintiff's disability and Dr. Emel's January 23, 2001 statement that plaintiff's medical condition 'does not' restrict her from work. By relying on the 1997 USPS accommodation to justify the denial, Hartford suggests that once an individual requests and receives accommodation for a disability, she foregoes future eligibility for LTD benefits. Hartford undertook no independent medical review of

changes in plaintiff's condition between the accommodation in 1997 and her retirement in 2000. Absent additional evidence, prior accommodation does not amount to substantial evidence on which to base a denial of LTD benefits. *See Hawkins v. First Union Corp. Long-Term Disability Plan,* 326 F.3d 914, 918 (7th Cir.2003) ("A disabled person should not be punished for heroic efforts to work by being held to have forfeited his entitlement to disability benefits should he stop working").

Further, Hartford's reliance on Dr. Emel's January 23, 2001 statement, which favors their decision, ignores his July 26, 2000 statement that plaintiff is disabled and his March 7, 2001 statement that she is incapable of sitting for more than one hour. The record suggests that Hartford gave undue weight to the January 23, 2001 statement. *See Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 834, 123 S.Ct. 1965, 155 L.Ed.2d 1034 (2003) ("Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence ..."). In addition, while independent medical examinations are not required to establish reasonableness, "[w]here, as here, a conflict of interest may impede the plan administrator's impartiality, the administrator best promotes the purposes of ERISA by obtaining an independent

> evaluation." *Fought*, 379 F.3d at 1015; *see Gaither v. Aetna Life Ins. Co.*, 388 F.3d 759, 773 (10th Cir.2004) ("fiduciaries cannot shut their eyes to readily available information when the evidence in the record suggests that the information might confirm the beneficiary's theory of entitlement and when they have little or no evidence in the record to refute that theory."). *Graham v. Hartford Life & Accident Ins. Co.*, 2006 WL 160309, P. 3-4 (N.D. Okla. 2006)

After making the above observations, the Court ordered "that defendant's November 27, 2001 final decision to deny plaintiff's claim for LTD benefits is hereby **REMANDED** to the Plan administrator for a full and fair redetermination of the claim." *Graham v. Hartford Life & Accident Ins. Co.*, at P.4.

It is important to point out that the Court is not telling the Defendant to accept any new evidence or reconsider the matter in light of the Court's interpretation of contract language or based upon any other finding or instruction that the Court is giving the Plan Administration. The Court is simply saying look at the same evidence you have, but this time look at it fully and fairly.

The Tenth Circuit has recognized that there is a split of authority over whether an order remanding a matter to an ERISA administrator is final.

"Circuit courts have split over whether an order remanding a matter to an ERISA plan administrator is final. The First, Sixth, and Eleventh Circuits have held that such orders are non-final. *See Bowers v. Sheet Metal Workers' Nat'l Pension Fund,* 365 F.3d 535, 537 (6th Cir.2004); *Petralia v. AT & T Global Info. Solutions Co.,* 114 F.3d 352, 354 (1st Cir.1997); *Shannon v. Jack Eckerd Corp.,* 55 F.3d 561, 563 (11th Cir.1995). The Seventh Circuit, however, considers ERISA remand orders to be final and appealable. *See Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan,* 195 F.3d 975, 977-80 (7th Cir.1999). In *Hensley v. N.W. Permanente P.C. Ret. Plan & Trust,* the Ninth Circuit employed an approach similar to our 'practical finality rule' and held that an ERISA remand order is final when 'appellate jurisdiction is necessary to ensure proper review of an important legal question which a remand may make effectively unreviewable.' 258 F.3d 986, 994 (9th Cir.2001) (*overruled on other grounds by Abatie v. Alta Health & Life Ins. Co.,* 458 F.3d 955, 966 (9th Cir.2006))." *Metzger v. UNUM Life Ins. Co. of America* 476 F.3d 1161, *1165 (10th Cir. 2007).

We first do not necessarily agree with the statement above regarding the First Circuit. The Tenth Circuit cites the case of *Petralia v. AT & T Global Info. Solutions Co.*, 114 F.3d 352, 354 (1st Cir. 1997). In that case, there was a procedural defect and not a full administrative review of the beneficiary's claim. The Order was that the Plan was to afford Ms. Petralia a full opportunity to establish her continued eligibility for short term benefits. We believe there is a difference between an order remanding a matter to the administrator for acceptance of further evidence and an order simply remanding the matter back for a fair determination. It appears that the Seventh Circuit would treat these type of remand orders differently. At this point, however, we would point out that we do not believe that the First Circuit as a matter of course believes all such remand orders are not subject to appeal. In a later case, the Circuit states that they review a district court's choice of remedy for an ERISA violation for an abuse of discretion.

> "An appellate court reviews a district court's choice of remedy for an ERISA violation for abuse of discretion. *Zervos v. Verizon New York Inc.*, 277 F.3d 635, 648 (2d Cir.2002); *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154, 1163 (9th Cir.2001). Once a court finds that an administrator has acted arbitrarily and capriciously in denying a claim for benefits, the court can either

remand the case to the administrator for a renewed evaluation of the claimant's case, or it can award a retroactive reinstatement of benefits. *See Welsh v. Burlington N., Inc., Employee Benefits Plan*, 54 F.3d 1331, 1340 (8th Cir.1995) (recognizing that a district court has power to calculate and award unpaid benefits).

Liberty cites the familiar proposition that ERISA 'provides no authority for a court to render a *de novo* determination of an employee's eligibility for benefits' in support of its argument that the district court could not award Cook retroactive benefits. *Peterson v. Cont'l Cas. Co.*, 282 F.3d 112, 117 (2d Cir.2002). Important though it is in many other contexts, this axiom underlying the principle of ERISA deference does not deprive a court of its discretion to formulate a necessary remedy when it determines that the plan has acted inappropriately. "[R]etroactive reinstatement of benefits is appropriate in ERISA cases where, as here, 'but for [the insurer's] arbitrary and capricious conduct, [the insured] would have continued to receive the benefits' or where 'there [was] no evidence in the record to support a termination or denial of benefits.' "

Grosz-Salomon, 237 F.3d at 1163 (modifications in original) (quoting *Quinn v. Blue Cross & Blue Shield Ass'n.*, 161 F.3d 472, 477 (7th Cir.1998)); *see also Zervos*, 277 F.3d at 648 ('**[A] remand of an ERISA action seeking benefits is inappropriate where the difficulty is not that the administrative record was incomplete but that a denial of benefits based on the record was unreasonable.**') (internal quotation marks omitted); *Levinson v. Reliance Standard Life Ins. Co.*, 245 F.3d 1321, 1330 (11th Cir.2001) ('We do not agree, however, that a remand to the plan administrator is appropriate in every case.'); *Grosz-Salomon*, 237 F.3d at 1163 ('[A] plan administrator will not get a second bite at the apple when its first decision was simply contrary to the facts.').

We acknowledge that several of these quotations may overstate the matter. We have no doubt that in some situations a district court, after finding a mistake in the denial of benefits, could conclude that the question of entitlement to benefits for a past period should be subject to further proceedings before the ERISA plan administrator.

This might be true, for example, if the denial is less flagrant than in this case and if there were good reason to doubt that a reassessment would justify benefits for some or all of the past period. However, the variety of situations is so great as to justify considerable discretion on the part of the district court and, in this instance, it has not been abused.

Liberty argues that there is no evidence of Cook's disability status after October 1998, when it terminated her disability benefits, and hence no basis for awarding her disability benefits past that date. However, the absence of information about Cook's disability status resulted directly from Liberty's arbitrary and capricious termination of her benefits. As a recipient of disability benefits, Cook was under a continuing obligation to adduce proof of her disability pursuant to the long-term disability plan. Once Liberty terminated her benefits, she was no longer obliged to update Liberty on her health status. It would be patently unfair to hold that an ERISA plaintiff has a continuing responsibility to update her former insurance company and the court on her disability during the pendency of her

internal appeals and litigation, on the off chance that she might prevail in her lawsuit. Moreover, as the district court notes in its decision, reconstruction of the evidence of disability during the years of litigation could be difficult for a recipient of long-term disability benefits wrongly terminated from a plan.

This is not to say that Liberty cannot terminate Cook's benefits in the future. Once she is reinstated to the plan, she will again be obligated to prove that she is disabled under the 'any occupation' definition listed in the plan documents. If she cannot do so, or if Liberty acquires sufficient evidence to contradict her doctor's opinion, it could pursue termination of her eligibility for benefits at that time.

The district court also awarded Cook attorney's fees, as it has discretion to do under 29 U.S.C. § 1132(g)(1). An appellate court reviews an award of attorney's fees solely for abuse of discretion. *Cottrill v. Sparrow, Johnson & Ursillo, Inc.*, 100 F.3d 220, 223 (1st Cir.1996). We find no abuse of discretion in that award." *Cook v. Liberty Life Assur. Co. of Boston* 320

F.3d 11, *24 -25 (1st Cir. 2003)
(emphasis added)

It goes without saying that the District Court's Order remanding the case back to the Plan Administrator for a fair determination is an equitable remedy. Thus, it appears that the First Circuit reviews such an order as a final appealable order and subject to appellate review under an abuse of discretion standard.

Moreover, despite the Tenth Circuit's analysis in the case of *Metzger v. UNUM Life Ins. Co. of America, supra,* it also appears that the Ninth Circuit Court of Appeals would likewise review such an order for an abuse of discretion.

> "When a district court's remedy takes the form of an equitable order, we review that order for an abuse of discretion. We find no such abuse here. Contrary to Paul Revere's assertion, retroactive reinstatement of benefits is appropriate in ERISA cases where, as here, 'but for [the insurer's] arbitrary and capricious conduct, [the insured] would have continued to receive the benefits' or where 'there [was] no evidence in the record to support a termination or denial of benefits.' In other words, a plan administrator will not get a second bite at the apple when

> its first decision was simply contrary to the facts. This court's decision in *Saffle v. Sierra Pacific Power Company Bargaining Unit Long Term Disability Income Plan* does not counsel to the contrary. *Saffle* stands for the proposition that 'remand for reevaluation of the merits of a claim is the correct course to follow when an ERISA plan administrator, with discretion to apply a plan, has misconstrued the Plan and applied a wrong standard to a benefits determination.' This proposition is both unremarkable and inapposite. First, as discussed above, the operative plan documents do not confer discretion on Paul Revere. Second, even if they did, Paul Revere did not misconstrue the definition of 'disabled,' or apply the wrong standard to evaluate Grosz-Salomon's claim. It applied the right standard, but came to the wrong conclusion. Under these circumstances, remand is not justified. Retroactive reinstatement of benefits was proper. *Grosz-Salomon v. Paul Revere Life Ins. Co.* 237 F.3d 1154, *1163 (9th Cir. 2001)

Perhaps the most comprehensive and certainly the best reasoned approach is that of the Seventh Circuit. After the Court determined that the

judgment was not too uncertain to be enforced and that the District Court did not plan to enter any further orders, the Court then turned to whether or not the nature of the relief ordered was a non-final order. In doing so, the Court also recognized the split of authority between the various Circuits.

> But the nature of the relief, a remand to UNUM, may do so. Although it is doubtful as an original matter that a district court may 'remand' ERISA claims, as if to administrative agencies, we have held that courts may treat welfare benefit plans just like administrative law judges implementing the Social Security disability-benefits program. *Quinn v. Blue Cross & Blue Shield Ass'n*, 161 F.3d 472, 476-78 (7th Cir.1998); *Schleibaum v. Kmart*, 153 F.3d 496, 503 (7th Cir.1998). That makes it necessary to determine whether a remand is appealable as a final decision under 28 U.S.C. § 1291.
>
> One court of appeals has answered 'yes' without analysis. *Snow v. Standard Insurance Co.*, 87 F.3d 327, 332 (9th Cir.1996). Two courts have answered 'no,' analogizing the remand to a district court's order setting the case for a new trial. *Petralia v. AT&T Global*

> *Information Solutions Co.*, 114 F.3d 352 (1st Cir.1997); *Shannon v. Jack Eckerd Corp.*, 55 F.3d 561 (11th Cir.1995). *Petralia* thought it implicit in a remand that the parties may return to the district court without filing a new complaint following the plan's fresh decision, and if so then the district court's decision cannot be called final. A more recent decision of the ninth circuit called *Petralia*' s assessment persuasive, *Williamson v. Unum Life Insurance Co.*, 160 F.3d 1247, 1252 (9th Cir.1998), though because the judgment in *Williamson* was not final by any standard (the district court had resolved a few disputed issues but had not awarded *any* relief) *Snow* was not overruled. A fourth court of appeals has noticed the conflict without taking a stand. *Crocco v. Xerox Corp.*, 137 F.3d 105, 108 (2d Cir.1998). Now it is our turn." *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan* 195 F.3d 975, *978 (7th Cir. 1999)

After recognizing a split of authority, the Court then took its stab at the issue. It is this writer's belief that this is the best and most well reasoned approach. The Seventh Circuit likened the remand of an ERISA matter back to the Plan Administrator like a remand of a matter back to a

Social Security Administrative Judge. Although the purpose of this Petition is simply to point out to the Court that there appears to be a split of authority between the Circuits, we would opine that this approach seems to be the best and the most well reasoned. In cases where additional evidence is needed or where a Plan Administrator needs to reevaluate evidence in light of a Court's direction where it is anticipated the Court will then make additional rulings based upon the expanded record, that certainly is not a final, appealable order. But where the Court makes a judgment affirming, modifying or reversing the decision, with or without remand, that would be an appealable order. Obviously, that is what we have in the case at bar. There is no direction or request that the Plan Administrator expand the Administrative Record but simply an order reversing the denial. There really is no additional evidence available. All of the relevant medical records of Shirley was before the Plan Administrator in the three tiered decision making process. An independent medical evaluation most certainly would tell us what Shirley Graham's condition is now but not what it was seven (7) years ago when she made application for her benefits. In any event, the analysis by the Seventh Circuit is certainly instructive but at this particular point it simply points out that there is at least a third way of reviewing whether or not an order remanding a claim for further proceedings before the Plan Administrator is a full and final appealable Order.

If the justification for a remand to an ERISA plan's administrator is that the plan makes the same kind of decisions as the Social Security Administration, then it is important to know the jurisdictional consequences of a remand in a Social Security case. Two sentences of 42 U.S.C. § 405(g) authorize remand in different situations. Sentence four authorizes the district court to enter 'a judgment affirming, modifying, or reversing the decision of the Commissioner of Social Security, with or without remanding the cause for a rehearing.' Sentence six allows the court to remand for the receipt of new evidence, but without entering a judgment determining the propriety of the decision previously rendered. *Sullivan v. Finkelstein*, 496 U.S. 617, 110 S.Ct. 2658, 110 L.Ed.2d 563 (1990), holds that a sentence-four remand, which depends on a finding of error in the Commissioner's decision, is appealable under § 1291 as a final decision, while a sentence-six remand is not final or appealable because no adjudication has taken place. See also *Forney v. Apfel*, 524 U.S. 266, 118 S.Ct. 1984, 141 L.Ed.2d 269 (1998). A sentence-four remand concludes the

litigation in the district court; any protest about the Commissioner's decision on remand requires a new suit. But a sentence-six remand works like a yo-yo; once the record has been enlarged, the district court finally decides whether the administrative decision is tenable. Remands to plan administrators serve the same functions as remands to the Commissioner, which implies the same jurisdictional treatment for purposes of § 1291. If the district court finds that the decision was erroneous and enters a judgment wrapping up the litigation, that decision is appealable even if extra-judicial proceedings lie ahead; but if the court postpones adjudication until after additional evidence has been analyzed, then it has not made a final decision. The Supreme Court drew this line in *Finkelstein* in part because it was concerned that it would otherwise be impossible for the Commissioner to obtain review of an adverse decision by a district court. If the court directs the Commissioner to apply a specific rule, or accept specific evidence, and the Commissioner carries out that directive and awards benefits, the case may never return to court. Unum may say the same about the remand ordered

here. *Petralia* assumed that the case was bound to come back to the district court, but as this example shows it need not do so. At all events, the Court added in *Forney*, an appeal under § 1291 does not depend on who won in the district court or whether the remand is likely to prevent renewed litigation. The rule is mechanical: all sentence-four remands are appealable. *Forney* holds that the claimant is as entitled to appeal a remand as is the Commissioner. Forney contended that she was entitled to immediate victory without the need for a remand, and the Supreme Court held that Forney could present this claim to the court of appeals before the remand occurred. Perlman occupies Forney's position, and unum occupies the Commissioner's position in *Finkelstein*, for the district court's remand is based on a finding of error (parallel to sentence four) rather than new evidence (sentence six). Just as in *Finkelstein* and *Forney*, the district court entered a Rule 58 judgment indicating that the decision to deny benefits was in error, and that the court is done with the case. "*Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan* 195 F.3d 975, *978 -979 (7th Cir. 1999)

In addition to analyzing cases dealing with Social Security remands, the Court also went on to analyze the issue of whether such orders are appealable comparing them to a remand to an arbitrator. In its analysis, it came to the same conclusion that such an order is subject to appellate jurisdiction.

> "Before concluding that ERISA remands are just like Social Security remands, we must consider a second possibility: that an ERISA remand is most similar to a remand to an arbitrator. Like an arbitrator, the administrator of an ERISA plan is a private dispute resolver. It therefore may be instructive to explore whether an order declining to enforce an award but directing additional arbitral proceedings is appealable.Our court first considered that question in *Shearson Loeb Rhoades, Inc. v. Much*, 754 F.2d 773 (7th Cir.1985). Recognizing that the circuits then were divided on the question, we came down firmly on the side of no appellate jurisdiction. Contemporaneously with *Much*, another circuit adopted a contrary view, *United Steelworkers v. Adbill Management Corp.*, 754 F.2d 138, 140 & n. 1 (3d Cir.1985) (equating a remand to an

order requiring arbitration in the first place), but we reaffirmed *Much* in *United Steelworkers v. Aurora Equipment Co.*, 830 F.2d 753 (7th Cir.1987). *Much* and *Aurora Equipment* give a common reason for their conclusion: that remands to arbitrators should be treated just like remands to administrative agencies, which at the time of *Much* and *Aurora Equipment* were widely thought to be non-final. Three years after *Aurora Equipment*, that premise was undermined by *Finkelstein*, and *Forney* has completed the process of making administrative remands generally appealable. So if we adhere to the rationale of *Much* and *Aurora Equipment*, the comparison of ERISA remands to arbitration remands does not lead in a new direction; it leads right back to the administrative-law analogy, and thus (today) to appellate jurisdiction. Neither *Much* nor *Aurora Equipment* has been cited since *Finkelstein*, but for a reason that does not reflect a change of heart about the classification of arbitral remands under § 1291. In 1988 Congress changed the rules for appeals from decisions concerning arbitration. Under 9 U.S.C. § 16(b) any order by a district court directing the parties to arbitrate is non-

appealable, but § 16(a)(1)(E) provides that any order 'modifying, correcting, or vacating an award' may be appealed immediately. Courts of appeals routinely assume, though without discussion, that an order vacating an arbitrator's decision but remanding for additional arbitration is appealable under § 16(a)(1)(E), rather than non-appealable under § 16(b). See, e.g., *Aircraft Braking Systems Corp. v. Automobile Workers*, 97 F.3d 155 (6th Cir.1996). *Aurora Equipment* supports the conclusion that a remand should not be treated like an original order to arbitrate, so this circuit, too, presumably will entertain jurisdiction under § 16(a)(1)(E) when the time comes. Thus whether we think of remands to arbitrators as equivalent to remands to agencies (the rationale of *Much* and *Aurora Equipment*) or as orders vacating awards, the remands would today be appealable, which offers further support for the conclusion that § 1291 permits appeal of a remand to an ERISA administrator.

Permitting appeals from remand orders does carry a cost-not only because it sets the stage for successive appeals if the decision on remand should be contested,

> but also because it causes the attorneys' fees dispute to come to a head prematurely. How is one to tell whether Perlman is a 'prevailing party' entitled to fees until we know the final outcome? It is tempting to treat the remand as non-final simply in order to postpone the fee question until the outcome is known. *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan* 195 F.3d 975, *979 -980 (7th Cir. 1999).

We thus see that there is a definite split of authorities between the various Circuits and this split of authority substantially affects the rights of beneficiaries and, in some instances, even Plan Administrators. Graham asserts that it is reasonable to believe that had this appeal been brought in the First, Fourth, Seventh or Ninth Circuit Court of Appeals she would now have an order addressing the merits of her appeal and, in all likelihood, would now be receiving her court ordered benefits and perhaps even preparing for her state court cause of action for insurance contract benefits and/or insurance bad faith. Even if our assessment is wrong on what the final appellate resolution would be, we feel we would at least have an end to the ERISA litigation and if nothing more, closure. These distinctions between the Circuits effect substantive rights and not for merely differing approaches to a complex legal decision. In one court, you get

resolution of your lawsuit. In another court, the beneficiary gets thrown back into the rabbit hole. The compelling reason for this Court to grant certiorari is that in some Circuit Courts you get to have your matter heard and in other Courts you do not even get resolution of your claim. It is difficult to imagine a situation where the different approaches of the Circuit Court of Appeals produces such a dramatic impact on the outcome of a matter.

2. MAKING REMAND ORDERS SUCH AS THE ONE BEFORE THIS COURT NON-APPEALABLE VIOLATES THE PURPOSE AND INTENT OF THE ERISA STATUES AND VIOLATES BENEFICIARIES' DUE PROCESS RIGHTS.

In the 1974 U.S. Code and Administrative News, in its final report the Committee stated as follows:

> "The enforcement provisions have been designed specifically to provide the secretary and the participants and their beneficiaries with broad remedies for redressing or permitting violation of the Retirement Income Security for Employees Act as well as the amendments made to Welfare Pension Disclosure Act. **The intent of the committee is to provide the full range of legal and equitable**

> **remedies available both in state and federal courts and to remove jurisdictional and procedural obstacles which in the past appear to have hampered effective enforcement of fiduciary responsibilities under state law for recovery of benefits due to participants."** 1974 U.S. Code and Administrative News, Page 4655.

As an attorney who has represented insureds and beneficiaries over the last seventeen (17) years, I yearn for the procedural obstacles which in the past appeared to have hampered enforcement of fiduciary responsibilities for the recovery of benefits due to the participants. That being said, it appears that nothing more than a legislative modification of ERISA would address much of the problems that we encounter at this particular point. However, this Court seems to be in a unique position regarding this particular issue. We are talking about what type of order would be an appealable order and who better to address question than this Court. Particularly in light of the fact that the various Circuit Courts seem to struggle mightily with this question and have developed different approaches which substantially and significantly affect the rights of the litigants depending on what circuit they live in.

Unquestionably, remand back Plan Administrators who can not muster enough evidence

to support their initial denial encourages wrongful denial and delays receipt of deserved benefits. Allowing remands such as this, does nothing more than to thwart and totally defeat the stated purposes of ERISA. This Court has the unique opportunity to breathe some life back into ERISA and its legislative intent.

CONCLUSION

Graham and her counsel obviously believe that there are strong public policy and fairness issues which would warrant a grant of certiorari and a consideration by this Court.

However, the strongest argument for certiorari is simply the fact that there is varying approaches to whether or not an order remanding a matter back to a Plan Administrator is a final and appealable order. These differences result in substantial and significant differences in the rights of litigants to have their matter fully, fairly and efficiently resolved. Regardless of how this Court would eventually come down on this issue of appealability of an order such as the one before this Court, it is essential that there be uniform and consistent handling of this issue throughout the Circuits.

Respectfully Submitted,

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PUBLISH

UNITED STATES COURT OF APPEALS

TENTH CIRCUIT

SHIRLEY A. GRAHAM,

Plaintiff-Appellant,

v. Nos. 06-5054 and 06-5142

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY,

Defendant-Appellee.

Appeal from the United States District Courtfor the Northern District of Oklahoma(D.C. No. 03-CV-0144-CVE)

Joseph F. Clark Jr., Clark & Warzynski, P.A., Tulsa, Oklahoma, for Plaintiff-Appellant.

Timothy A. Carney, Gable & Gotwals, Tulsa, Oklahoma, for Defendant-Appellee.

Before KELLY and EBEL, Circuit Judges, and MURGUIA,* District Judge.

EBEL, Circuit Judge

*Honorable Carlos Murguia, District Court Judge, District of Kansas, sitting by designation.

Plaintiff-Appellant Shirley A. Graham brought suit after she was denied long-term disability benefits under a plan administered by Defendant-Appellee Hartford Life & Accident Insurance Company ("Hartford"). The District Court for the Northern District of Oklahoma concluded that Hartford's denial of Graham's claim violated the Employment Retirement Income Security Act (ERISA) because Hartford's decision was arbitrary and capricious. The court did not award Graham benefits, but instead remanded the claim to Hartford for a "full and fair redetermination." Graham appeals both the decision to remand and the court's earlier decision that ERISA preempted her state law claim. (No. 06-5054.) In companion case No. 06-5142, Graham appeals the court's denial of her request for attorney's fees.

We conclude that the district court's order to remand Graham's claim for benefits to Hartford is not a final decision that gives rise to our jurisdiction under 28 U.S.C. § 1291. Because Graham will have the

opportunity later to appeal the issues before us once a final judgment has been entered, we DISMISS this appeal for lack of jurisdiction. We further hold that Graham's related action for attorney's fees is not ripe, and therefore VACATE the district court's denial of her request for fees, and REMAND with directions to dismiss her motion without prejudice.

I. Background

Graham was employed by the United States Postal Service since 1976 as a mail carrier. She also was a member of the relevant collective-bargaining union, the National Rural Letter Carriers' Association ("NRLCA"). In 1994, while carrying mail, Graham encountered a small but aggressive dog. In stepping away from the dog, she backed off the sidewalk and twisted her knee. This injury required surgery and precipitated more problems in her knees and feet, including osteoarthritis. Despite her attempt to work in a sedentary position for the Postal Service from 1997 to 2000, she continued to have health problems.

NRLCA offered its members the opportunity to participate in a long-term disability insurance plan. Even though the collective bargaining agreement with the Postal Service did not provide for such a plan, the NRLCA arranged for the Postal Service to deduct premiums from its participating employees' paychecks. Graham applied to participate in the NRLCA's long-term disability benefits plan, and became insured on November 22, 1997.

Graham's last day of work was July 15, 2000. She applied for disability retirement with the Postal Service, which was approved on December 1, 2000. On October 27, 2000, Graham filed a claim for long-term disability benefits with Hartford, the administrator of NRLCA's long-term disability plan. Graham submitted a statement from her attending physician, Dr. Jeffrey Emel, that diagnosed ankle osteophytes and an ankle sprain. Hartford considered Graham's claim in early 2001, and sought a clarification from Dr. Emel regarding Graham's ankle and knee problems. Hartford then denied Graham's claim on the basis that she did not meet the plan's definition of "totally" disabled, defined as unable to perform the essential duties of one's occupation and as a result earn less than 20 percent of one's pre-disability earnings. Hartford specifically concluded that Graham's most recent occupation was classified as sedentary, and that she had not shown that she could not perform sedentary work. Graham appealed, submitting additional documentation from Dr. Emel in which he stated that Graham could not drive or sit for more than an hour at any one time. However, Hartford again rejected Graham's claim on the same basis as its previous denial. Graham made a second and final internal appeal to Hartford, which again denied her claim because it concluded a job that accommodated her disability was available to her.

Having exhausted her internal appeals, Graham filed suit in federal court on February 27, 2003, invoking the court's diversity jurisdiction. She alleged

that Hartford had breached its duty of good faith and fair dealing-an Oklahoma state law claim-by failing to investigate, evaluate and pay Graham's claims properly. She further alleged that Hartford's "malicious" and "intentional" conduct had caused her extreme emotional distress and financial losses. As a remedy, she sought actual and punitive damages.

Graham's complaint did not mention ERISA. ERISA provides a private right of action to a beneficiary under an ERISA-covered plan, but limits a claimant's remedies to "recover[y of] benefits due to him" and "enforce[ment of] his rights under the terms of the plan." 29 U.S.C. § 1132(a)(1)(B). ERISA does not allow consequential or punitive damages. See Allison v. UNUM Life Ins. Co., 381 F.3d 1015, 1025 (10th Cir.2004).

The district court first decided that the NRLCA plan was governed by ERISA, and that ERISA preempted Graham's state law claim. Specifically, the court found that the NRLCA plan did not fall under the "governmental plan" exception to ERISA coverage, because the union-offered insurance lacked an adequate connection to governmental control, functional responsibilities and financial support. The district court accordingly dismissed Graham's state law claim against Hartford. The court then ordered the parties to submit an administrative record within 45 days so the court could review the merits of Graham's claim for benefits under the NRLCA plan. In so doing, the court apparently converted Graham's complaint to

an ERISA action. There is no indication in the record that Graham objected at this time to the court's decision to substitute her state law claim with one brought under ERISA.

Eight months later, the district court ruled on the merits of Graham's claim for benefits.[1] Employing

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[1]Neither the parties nor the court precisely described the procedural posture of the case at the time the court rendered its decision to remand Graham's claim. Graham initially submitted a brief to the district court on her "entitlement to benefits" by calling it a "motion for judgment as a matter of law." The clerk requested that Graham refile the document as a brief. Hartford responded, also in the form of a brief. The district court's resulting decision simply addresses the merits of Graham's claim under ERISA without reference to any of the motions for judgment permitted under the Federal Rules of Civil Procedure.

Even though ERISA claims have a distinct standard of review, see Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 109 S.Ct. 948, 103 L.Ed.2d 80 (1989) and Fought v. UNUM Life Ins. Co., 379 F.3d 997, 1002, 1006 (10th Cir.2004), we expect a district court's resolution of those claims to comport with the Federal Rules of Civil Procedure, which typically would be to treat them as a motion for summary judgment. See, e.g., Allison, 381 F.3d at 1020; Fought, 379 F.3d at 999, 1002; Rekstad v. First Bank Sys., 238 F.3d 1259, 1261-62 (10th Cir.2001); Albright v. UNUM Life Ins. Co., 59 F.3d 1089, 1091 (10th Cir.1995).

ERISA, the court concluded that Hartford's decision was arbitrary and capricious, specifically that it failed to prove that its denial of benefits was supported by substantial evidence under Sandoval v. Aetna Life & Cas. Ins. Co., 967 F.2d 377, 382 (10th Cir.1992). The court faulted Hartford for: relying on the fact that Graham had been able to work in a modified job for the Postal Service, even though the Postal Service established the accommodation three years prior to her disability benefits claim; giving undue weight to a single statement by her treating physician that was not consistent with the other medical evidence in the record; and not undertaking an independent medical review in the face of conflicting evidence. The court did not state that Graham was necessarily eligible for disability benefits, but instead found that, in "[v]iewing the record as a whole," Hartford did not meet its evidentiary burden to support the denial of benefits to Graham.

The district court did not award Graham benefits; instead, the court remanded her claim to Hartford "for a full and fair redetermination." The district court did not state whether or not it would retain jurisdiction over the matter. However, the docket entries administratively entered for this decision indicate that the court was "dismissing/terminating" the case.

Graham petitioned the district court for attorney's fees, which may be awarded at the court's discretion under ERISA. See 29 U.S.C. § 1132(g)(1). The court applied our five-factor standard from Gordon v. U.S. Steel Corp., 724 F.2d 106, 109 (10th Cir.1983), and determined that a fee award would be inappropriate. Specifically, the court said it had made no finding of bad faith on the part of Hartford, and noted that "the record does not suggest that plaintiff's claim for benefits is particularly meritorious."

On appeal, Graham: (1) seeks to revive her state law claim, contending that NRLCA's disability insurance is a governmental plan exempt from ERISA because the Postal Service recognizes the NRLCA as a collective-bargaining union; (2) argues that the court should have awarded her disability benefits rather than remanding the claim to Hartford; and (3) asserts that an award of attorney's fees is appropriate, alleging that Hartford engaged in "bad faith" conduct.

Hartford does not appeal the district court's conclusion that its decision was arbitrary and

capricious. Instead, Hartford argues that we have no jurisdiction over this appeal, on the theory that a district court's decision to remand a claim to a plan administrator is not a final appealable decision under the meaning of 28 U.S.C. § 1291.

II. Jurisdiction and Finality

We have jurisdiction "of appeals from all final decisions of the district courts of the United States." 28 U.S.C. § 1291. "It is well settled that we can only address the underlying merits of a lawsuit if it meets the requirements for appellate jurisdiction outlined in 28 U.S.C. § 1291." Albright v. UNUM Life Ins. Co., 59 F.3d 1089, 1092 (10th Cir.1995). "A final decision is one that 'ends the litigation on the merits and leaves nothing for the court to do but execute the judgment.' " Rekstad v. First Bank Sys., 238 F.3d 1259, 1261 (10th Cir.2001) (quoting Catlin v. United States, 324 U.S. 229, 233, 65 S.Ct. 631, 89 L.Ed. 911 (1945)). "In considering whether the judgment constitutes a 'final decision' under § 1291, the label used to describe the judicial demand is not controlling-that is, we must analyze the substance of the district court's decision, not its label or form." Albright, 59 F.3d at 1092 (quotation, citation omitted).

Thus, we must determine if the district court's order to remand, which is the decision giving rise to

this appeal, is final.[2] The Tenth Circuit has declined to adopt a hard-and-fast rule regarding whether a district court's order remanding a benefits determination to a plan administrator is final, and therefore appealable, under 28 U.S.C. § 1291. "The decision should be made on a case-by-case basis applying well-settled principles governing 'final decisions.' " Rekstad, 238 F.3d at 1263; see also Metzger v. UNUM Life Ins. Co., 476 F.3d 1161, 1164 (10th Cir.2007) (same). In Rekstad, both parties appealed a district court's order to remand a benefits determination claim to the plan administrator after the court concluded that the administrator's decision to deny benefits was arbitrary and capricious because it unreasonably relied on one particular doctor's medical examination. 238 F.3d at 1261. We held that the decision to remand was not final in that case.

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[2]Graham potentially could have immediately appealed from the district court's initial decision dismissing her state law claim, which was the *only* claim she alleged in her complaint. She has not done so, though, and instead acquiesced to the district court's conversion of the suit to one stating an ERISA claim. Her notice of appeal characterizes that the earlier decision was interlocutory. The limited statutory exception for permitting interlocutory appeals at 28 U.S.C. § 1292(b) is not met here, because the district court did not certify that the decision should be immediately appealable, and Graham did not request that the court do so.

Likening a benefits determination to a computation of damages, we noted that we had previously held that "a district court's grant of summary judgment to the plaintiff on an ERISA claim that left the question of damages unresolved was not a final appealable order." Id. at 1262 (citing Albright, 59 F.3d 1089). "[T]he well-accepted rule [is] that an order determining liability but leaving damages to be calculated is not final unless the correct amount of damages is self-evident and not likely to be the subject of future appeal." Id. And a district court's remand of a benefits decision to a plan administrator similarly is indeterminate. Id.

In Rekstad, we also drew a comparison between a district court's remand to a plan administrator and a remand to an administrative agency, calling it "perhaps the best analogue to an ERISA remand." Id. at 1262. "In the administrative context, a remand order is 'generally considered a nonfinal decision ... not subject to immediate review in the court of appeals.' " Id. (quoting Baca-Prieto v. Guigni, 95 F.3d 1006, 1008 (10th Cir.1996)). We recently reiterated the administrative agency analogue in Metzger. See 476 F.3d at 1164.

However, we also have held that the "practical finality rule" provides an important caveat that could result in jurisdiction over an appeal of a remand decision. Rekstad, 238 F.3d at 1262. The practical finality rule may be invoked when the lack of immediate review of an order for an administrative

remand "would violate basic judicial principles." Baca-Prieto, 95 F.3d at 1008 (quoting Bender v. Clark, 744 F.2d 1424, 1427 (10th Cir.1984)). "In the context of a district court order remanding a matter to an administrative agency, jurisdiction may be appropriate when the issue presented is both urgent and important." Trout Unlimited v. U.S. Dep't of Agric., 441 F.3d 1214, 1218 (10th Cir.2006) (citing Bender, 744 F.2d at 1427). "If these two conditions are met, this court will apply a balancing test and assert jurisdiction if 'the danger of injustice by delaying appellate review outweighs the inconvenience and costs of piecemeal review.' " Id. (quoting Bender, 744 F.2d at 1427). Under this rule, we review orders to remand a matter to an administrative agency when it is necessary to ensure that we can review important legal questions which a remand may make "effectively unreviewable," because administrative agencies "may be barred from seeking district court (and thus circuit court) review of their own administrative decisions." Rekstad, 238 F.3d at 1262 [3] see also Metzger, 476 F.3d at 1165

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[3] Rekstad's formulation of the practical finality rule borrows some concepts from the collateral order doctrine, which also provides a limited avenue for appealing an order that otherwise might be deemed non-final. The Supreme Court articulated the standards for appealing collateral orders in Cohen v. Beneficial Industrial Loan Corp. See337 U.S. 541, 546, 69 S.Ct. 1221, 93 L.Ed. 1528 (1949). "To be appealable under the collateral order doctrine, an order must

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[1] conclusively determine the disputed question, [2] resolve an important issue completely separate from the merits of the action, and [3] be effectively unreviewable on appeal from a final judgment." Stubblefield v. Windsor Capital Group, 74 F.3d 990, 997 (10th Cir. 1996) (applying Cohen (quotation omitted)); see also Timpanogos Tribe v. Conway, 286 F.3d 1195, 1200 (10th Cir.2002) (describing applicability of the collateral order doctrine over "an extremely narrow class of claims raised interlocutorily," and noting that the rule "sets a high bar").

The "practical finality rule," derived from Gillespie v. U.S. Steel Corp., 379 U.S. 148, 152-53, 85 S.Ct. 308, 13 L.Ed.2d 199 (1964), provides a somewhat broader opportunity for appeal than the collateral order doctrine. "[T]he finality requirements of 28 U.S.C. § 1291... need not strictly come within the Cohen [ ] 'collateral order' doctrine if, in a practical sense, justice may require immediate review." Cotton Petroleum Corp. v. U.S. Dep't of Interior, 870 F.2d 1515, 1522 (10th Cir.1989) (citing Bender, 744 F.2d at 1426-27). We have contrasted the "balancing test" of the practical finality rule with "the mechanical analysis of the collateral order doctrine."Id. (quoting Bender, 4 F.2d at 1427).

We have observed that the practical finality rule has led a "checkered life ... in both our court and the United States Supreme Court," and we have "openly questioned whether [the] doctrine of practical finality is still viable." Baca-Prieto, 95 F.3d at 1009 (quotations omitted). We have suggested, though, that the doctrine is more robust in the context of agency review. See id. (noting that "this court has developed a particular form of practical finality ... as a prudential limitation on the administrative-remand rule"); Rekstad, 238 F.3d at 1262 (noting the practical finality rule "exists in the administrative agency context, if nowhere else"). Still, we have cautioned that the doctrine "must be narrowly construed to preserve the vitality of § 1291." Trout Unlimited, 441 F.3d at 1219 (alteration, quotation omitted).

Pursuant to Rekstad's rule that we evaluate the finality of an ERISA remand order on a case-by-case basis, and applying the factors discussed in Rekstad, the district court's order here remanding Graham's claim to Hartford is not final. The district court did not decide that Graham was eligible for benefits. It concluded only that Hartford's denial of her benefits violated ERISA because Hartford's decision was arbitrary and capricious. Graham articulates no argument that a remand of her benefits claim to Hartford falls within the practical finality exception employed by this circuit. [4]e discern nothing on appeal

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[4] Although Graham filed a supplemental brief devoted solely to the question of jurisdiction and

that is "urgent" or presents a "danger of injustice" if not immediately appealable. Trout Unlimited, 441 F.3d at 1218.

Hartford's redetermination of Graham's claim-which, Hartford assured the court at oral argument, would be de novo-may lead to an award of benefits for Graham. If Hartford again determines that Graham is ineligible for benefits, she may return to district court to argue that Hartford's decision violates ERISA [5]e observe that Hartford has conceded that if its benefits determination on remand "is unfavorable to [Graham], she may simply move to reopen the case, or file an amended complaint to address any dissatisfaction with Hartford's decision on remand."

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finality, her main argument was that the district court erred in ordering a remand to Hartford rather than directing an award of benefits. This line of argument conflates the merits of her appeal with the question of jurisdiction, since even if the district court's decision to remand was patently wrong, it would not necessarily be final within the meaning of 28 U.S.C. § 1291.

[5]Our conclusion interprets the district court's ERISA remand order as permitting either party to challenge the plan administrator's new eligibility determination. See Bowers v. Sheet Metal Workers' Nat'l Pension Fund, 365 F.3d 535, 537 (6th Cir.2004).

Graham argues that the district court's decision to remand is final in her case because it is based on the earlier decision to dismiss her state law claim that sought punitive damages, a type of relief that is not available from either a plan administrator on remand or a court reviewing the decision under ERISA.[6] But this argument does not change the availability of appellate review after Hartford redetermines Graham's claim for benefits. After the remand to Hartford, Graham still can appeal the district court's decision that ERISA preempts her state law claim, and if successful, she will be able to pursue punitive damages. In other words, this is not a situation in which remand may make either the district court's earlier decision that ERISA preempted Graham's state law claim or the merits of Hartford's decision on Graham's claim for benefits "effectively unreviewable." Rekstad, 238 F.3d at 1262.

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[6]Oklahoma law provides that "[t]ort liability for breach of th[e] duty [of good faith and fear dealing] arises where there is a clear showing that the insurance company unreasonably and in bad faith withheld payment of the claim of the insured." Hale v. A.G. Ins. Co., 138 P.3d 567, 572 (Okla.Ct.Civ.App.2006) (citing Christian v. Am. Home Assur. Co., 577 P.2d 899, 901 (Okla.1977), which holds that breach of the duty of good faith permits the insured to "recover consequential and, in a proper case, punitive, damages").

Graham also contends that the order is a final judgment, because to hold otherwise allows a plan administrator to delay awarding benefits with impunity, since the administrator is not penalized for improperly denying benefits in the first instance. But the mere fact that ERISA does not expressly penalize a plan administrator for its initial arbitrary and capricious denial-an issue of statutory design that rests in the hands of Congress-does not warrant a change in our jurisprudence surrounding finality.7

We note that although circuits vary on how they approach the issue of finality in cases involving ERISA remand orders, see Metzger, 476 F.3d at 1165 n. 1 (describing the circuit split), Graham would fare no better under most of those approaches. The majority of circuits have relied on one of the analogues invoked in Rekstad or the collateral order doctrine in deciding whether a decision to remand a benefits decision to a plan administrator is final. See Borntrager v. Cent. States, Se. & Sw. Areas Pension Fund, 425 F.3d 1087, 1090, 1092 (8th Cir.2005) (following the First, Sixth, Ninth, Tenth and Eleventh Circuits in holding that "an order remanding to an ERISA plan administrator for further proceedings is interlocutory in nature and therefore not immediately appealable, particularly

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7 In any event, ERISA authorizes a district court to award attorney's fees see 29 U.S.C. §1132(g)(1), which likely provides a disincentive for a plan administrator to engage in dilatory tactics purely for the sake of delaying benefits.

when the district court retained jurisdiction or otherwise deferred considering the merits of the administrator's decision being reviewed"). The Sixth Circuit has found that an order to remand was not final, in part because the "assessment of damages or awarding of other relief remains to be resolved." Bowers v. Sheet Metal Workers' Nat'l Pension Fund, 365 F.3d 535, 536 (6th Cir.2004) (quoting Liberty Mut. Ins. Co. v. Wetzel, 424 U.S. 737, 744, 96 S.Ct. 1202, 47 L.Ed.2d 435 (1976)).

A number of other circuits apply the comparatively strict collateral order doctrine as a means for appealing a remand to a plan administrator, and in cases similar to the one at bar, hold that a district court remand order is not final. See Borntrager, 425 F.3d at 1092 (reiterating Supreme Court precedent that the doctrine is a "narrow exception" and noting that "[w]hile there may be factors unique to the world of administrative law that justify a somewhat broader final order exception for orders remanding to federal agencies, in our view no such factors apply to orders remanding to private ERISA plan administrators"); Petralia v. AT & T Global Info. Solutions Co., 114 F.3d 352, 354 (1st Cir.1997) (holding a remand order was not final under the collateral order doctrine, since the issue remanded to the plan was the plaintiff's "continued eligibility for benefits," which was "the very heart of th[e] case"); Shannon v. Jack Eckerd Corp., 55 F.3d 561, 563 (11th Cir.1995) (similarly holding that the decision to remand is not "completely separate" from the merits,

but rather is "inextricably intertwined with the merits of [the claimant's] eligibility for benefits")[8]The Seventh Circuit has taken a minority approach that often concludes that ERISA remand orders are final and appealable. That court observed that "[r]emands to

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[8]The Ninth Circuit has applied to ERISA decisions a hybrid of the practical finality and collateral order doctrines in assessing whether a district court's remand to a plan administrator is final and appealable. Hensley v. Nw. Permanente P.C. Ret. Plan & Trust, 258 F.3d 986, 993 (9th Cir.2001) (defining three factors as "(1) the district court order conclusively resolved a separable legal issue, (2) the remand order forces the agency to apply a potentially erroneous rule which may result in a wasted proceeding, and (3) review would, as a practical matter, be foreclosed if an immediate appeal were unavailable").
The Hensley court found that its remand order was a final and appealable decision, because it met all three factors. Central to the dispute was whether the plaintiffs were "employees" under the plan-a severable legal issue necessary to deciding whether the plaintiffs were eligible for plan benefits-and because the plan had determined they were not employees, the plan had never addressed the merits of their claims. Id. at 990-91. Our matter differs in that Hartford does not dispute that Graham is a plan participant, has addressed the merits of her claim for benefits, and will do so again on remand.

plan administrators serve the same functions as remands to the Commissioner [of Social Security], which implies the same jurisdictional treatment for purposes of § 1291." Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan, 195 F.3d 975, 978-79 (7th Cir.1999) (discussing 42 U.S.C. § 405(g) and Sullivan v. Finkelstein, 496 U.S. 617, 625, 110 S.Ct. 2658, 110 L.Ed.2d 563 (1990)). The Perlman court also drew support from an analogy to arbitration, since the Federal Arbitration Act permits appeals of district court orders vacating arbitration awards, 9 U.S.C. § 16(a)(1)(E), and a court order to remand to a plan administrator for redetermination is comparable to vacating the plan's denial decision. Perlman, 195 F.3d at 980. However, this minority approach has not been adopted by this circuit, and has not attracted support from other circuits either. Specifically, the Sixth Circuit has criticized the argument comparing ERISA to Social Security remands, noting:

> ...42 U.S.C. § 405(g) specifically grants courts of appeals jurisdiction over orders remanding social security claims to the Commissioner [of Social Security]. No statutory language permits similar appeals under ERISA. The existence of language authorizing appeals from remand orders under the social security laws implies that those orders would not constitute final decisions under 28 U.S.C. § 1291. In the absence of a statutory grant of jurisdiction, this court declines to expand its jurisdiction by analogy.

Bowers, 365 F.3d at 537-38. We reject the minority approach here as well.

Finally, Graham contends that the district court's remand order is final because the court intended its decision to be final, pointing to the docket entries for the January 20, 2006, order and judgment remanding her claim to Hartford, at which the clerk states under each entry, "terminates case." Furthermore, a separate entry was made in the docket for January 20, 2006, stating "Civil Case Terminated."

However, when we question the finality of a district court's decision to remand a benefits determination to the plan administrator, we "analyze the substance of the district court's decision, not its label or form." Albright, 59 F.3d at 1092. For example, in Metzger, we drew no legal conclusions from the fact that the district court had earlier determined that its 2004 remand order was final, because the court effectively amended that order by reversing itself in 2006. Metzger, 476 F.3d at 1164-65. Instead, we held that this series of events rendered the first order interlocutory. Other courts similarly have disregarded the administrative entries regarding the status of an ERISA case when it is clear that the last district court decision was not a final judgment. See, e.g., Petralia, 114 F.3d at 355; Borntrager, 425 F.3d at 1090-91; Williamson v. UNUM Life Ins. Co., 160 F.3d 1247, 1253 (9th Cir.1998). We follow the same path here in holding that regardless of the

notations in the docket entries for the district court's remand decision, that decision is non-final in substance for the reasons given above.

Accordingly, we dismiss this appeal for lack of jurisdiction under 28 U.S.C. § 1291.

III. Attorney's Fees

Graham requests that we reverse the district court's decision not to award attorney's fees that are authorized in ERISA actions.[9] However, we conclude that the motion for fees was not ripe before the district court, and therefore we vacate the district court's 1decision and remand with instructions to dismiss the motion without prejudice.

"The ripeness doctrine stems from the 'cases and controversies' requirement in Article III, and it also reflects important prudential limitations on a court's exercise of jurisdiction." Salt Lake Tribune Publ'g Co. v. Mgmt. Planning, Inc., 454 F.3d 1128, 1140 (10th Cir.2006) (quotation, alterations omitted). "[R]ipeness is a justiciability doctrine designed to

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[9]See 29 U.S.C. § 1132(g)(1) ("In any action under this title ... by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.").

prevent the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements." Morgan v. McCotter, 365 F.3d 882, 890 (10th Cir.2004) (quoting Nat'l Park Hospitality Ass'n v. Dep't of Interior, 538 U.S. 803, 807, 123 S.Ct. 2026, 155 L.Ed.2d 1017 (2003)). A question of ripeness focuses on "whether the harm asserted has matured sufficiently to warrant judicial intervention." Id. (quoting Warth v. Seldin, 422 U.S. 490, 499 n. 10, 95 S.Ct. 2197, 45 L.Ed.2d 343 (1975)). "Determining whether the issues presented by this case are ripe for review requires us to evaluate both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." Id. (quotation omitted).

Courts vacate attorney's fees decisions when the presence of ongoing litigation precludes an informed determination of whether the moving party is in fact entitled to attorney's fees under the relevant law. See, e.g., Bennett v. Coors Brewing Co., 189 F.3d 1221, 1238, 1239 (10th Cir.1999); see also Principal Life Ins. Co. v. Robinson, 394 F.3d 665, 674 (9th Cir.2004); Star Phoenix Mining Co. v. West One Bank, 147 F.3d 1145, 1148 (9th Cir.1998)

Courts considering whether to award attorney's fees in ERISA actions consider five factors: a party's culpability or bad faith; its ability to satisfy an award of fees; the deterrence value of an award; the number of plan participants affected by the case or the

significance of the impact of the legal question involved; and "the relative merits of the parties' positions." Gordon, 724 F.2d at 109. We also afford certain weight to prevailing party status, even though we acknowledge that the ERISA attorney's fees provision is not expressly directed at prevailing parties. See, e.g., Deboard v. Sunshine Mining & Ref. Co., 208 F.3d 1228, 1245 (10th Cir.2000) (reversing and remanding an attorney's fee award because appellate decision "alter[ed] the relative merits of the parties' positions"); Morgan v. Indep. Drivers Ass'n Pension Plan, 975 F.2d 1467, 1471 (10th Cir.1992) ("Although the statute does not expressly require that a party prevail as a condition to receiving an award of attorneys' fees ... we have remanded cases for denial of fees without explanation only when the party seeking fees had prevailed at least partially."(citations omitted)); Arfsten v. Frontier Airlines, Inc. Ret. Plan for Pilots, 967 F.2d 438, 442 n. 3 (10th Cir.1992) ("Because we reverse the district court's decision on the merits, plaintiff is not a prevailing party, and his arguments on attorney's fees are moot.").

In this case, the district court denied Graham's motion for attorney's fees, concluding that its determination that Hartford acted arbitrarily and capriciously did not equate to a finding of bad faith under the first Gordon factor. The court found two other Gordon factors similarly were not satisfied here, because (1) Graham pursued benefits for only herself and her action did not involve a significant legal question and (2) the record did not suggest that her

claim for benefits was "particularly meritorious." Ordinarily, we review district courts' attorney's fees decisions for abuse of discretion. Gordon, 724 F.2d at 108.At this point in the litigation, however, a decision regarding attorney's fees is premature. The district court cannot properly apply the five-factor Gordon test, particularly with respect to the merits of the parties' positions and the impact of the litigation on other beneficiaries, when it remains to be seen whether Graham is entitled to benefits under the plan. Hartford will make a new determination of Graham's eligibility for benefits, and if eligibility is denied again, Graham will have the opportunity to re-argue before the district court that Hartford's new decision violates ERISA. The issues presented in Graham's motion for attorney's fees are not "fit" for judicial decision at this time. Morgan, 365 F.3d at 890. [10]

In dismissing the current fee motion on grounds of ripeness, we do not intend to create a per se rule

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[10] Graham argues that courts need to award attorney's fees in ERISA cases even at the remand stage in light of the realities of ERISA litigation, which often feature a plaintiff suffering from health problems who can afford to hire a lawyer only on a contingency fee arrangement. However, initiating this type of policy decision in authorizing attorney's fees properly lies with Congress.

that attorney's fees are inappropriate whenever a district court decides to remand a claim to the plan administrator rather than ordering benefits directly.[11] ERISA provides procedural protections to plan participants by statute and in its implementing regulations, which require plan administrators to provide certain notices and appeals procedures in making benefits determinations. *See, e.g.*,29 C.F.R. § 2560.503-1 (setting forth minimum requirements for claims procedures in employee benefit plans). It is theoretically possible for a claimant to bring suit for egregious violations of ERISA's procedural protections and, upon remand to the plan administrator, still not succeed in obtaining benefits. The judicial discretion provided by 29 U.S.C. § 1132(g)(1) and our five-factor Gordon test permit a court, in the right case, to reward plaintiffs for holding plans accountable under ERISA.

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[11]Hartford argues that we have no jurisdiction over the appeal of the denial of attorney's fees because the underlying order to remand to the plan administrator is not a final decision within the meaning of 28 U.S.C. § 1291. However, a petition for attorney's fees is considered "collateral to and separate from" the decision on the case's merits. Budinich v. Becton Dickinson & Co., 486 U.S. 196, 200, 108 S.Ct. 1717, 100 L.Ed.2d 178 (1988) (quotation omitted). Because our guidance on awarding attorney's fees under ERISA does not necessarily preclude an award when the district court remands a claim to the plan administrator, the district court's decision regarding fees in such a case is not inherently interlocutory.

However, Graham does not argue that Hartford systemically is violating ERISA procedures-and indeed, does not cite to any specific regulatory or procedural violation by Hartford-that would have made the issue of attorney's fees ripe in this case.

Because the district court decided the issue of attorney's fees before it was ripe, we vacate that decision and remand with instructions to dismiss without prejudice Graham's claim for fees.

IV. Conclusion

We hold that the district court's decision remanding Graham's claim to Hartford for a full and fair redetermination of her eligibility for long-term disability benefits is not a final decision under the meaning of 28 U.S.C. § 1291, and therefore we DISMISS appeal No. 06-5054 for lack of jurisdiction. We conclude that, under the facts of this case, the related action for attorney's fees, No. 06-5142, is not ripe, because several of the factors we assess for the appropriateness of fees cannot be ascertained until Hartford redetermines Graham's entitlement to benefits. Therefore, we VACATE the district court's denial of Graham's motion for attorney's fees and REMAND with instructions to dismiss her motion without prejudice.

APPENDIX

28 U..S.C.A. § 1291

UNITED STATES CODE ANNOTATED

TITLE 28. JUDICIARY AND JUDICIAL PROCEDURE

CHAPTER 83 - COURTS OF APPEALS

§ 1291. Final decisions of district courts

The courts of appeals (other than the United States Court of Appeals for the Federal Circuit) shall have jurisdiction of appeals from all final decisions of the district courts of the United States, the United States District Court for the District of the Canal Zone, the District Court of Guam, and the District Court of the Virgin Islands, except where a direct review may be had in the Supreme Court. The jurisdiction of the United States Court of Appeals for the Federal Circuit shall be limited to the jurisdiction described in sections 1292(c) and (d) and 1295 of this title.

29 U.S.C.A. § 1132

UNITED STATES CODE ANNOTATEDTITLE 29. LABORCHAPTER 18 - EMPLOYEE RETIREMENTINCOME SECURITY PROGRAMSUBCHAPTER I - PROTECTION OFEMPLOYEE BENEFIT RIGHTSSUBTITLE B - REGULATORY PROVISIONSPART 5 - ADMINISTRATION AND ENFORCEMENT

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the he Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any

provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter;

(6) by the Secretary to collect any civil penalty under paragraph (2), (4), (5), or (6) of subsection (c) of this section or under subsection (i) or (1) of this section;

(7) by a State to enforce compliance with a qualified medical child support order (as defined in section 1169(a)(2)(A) of this title);

(8) by the Secretary, or by an employer or other person referred to in section 1021(f)(1) of this title, (A) to enjoin any act or practice which violates subsection (f) of section 1021 of this title, or (B) to obtain appropriate equitable relief (i) to redress such violation or (ii) to enforce such subsection; or

(9) in the event that the purchase of an insurance contract or insurance annuity in connection with termination of an individual's status as a participant covered under a pension plan with respect to all or any portion of the participant's pension benefit under such plan constitutes a violation of part 4 of this title of[12] the terms of the plan, by the Secretary, by any individual who was a participant or beneficiary at the time of the alleged violation, or by a fiduciary, to obtain appropriate relief, including the posting of security if necessary, to assure receipt by the participant or beneficiary of the amounts provided or to be provided by such insurance contract or annuity, plus reasonable prejudgment interest on such amounts.

(b) Plans qualified under Internal Revenue Code; maintenance of actions involving delinquent contributions.

(1) In the case of a plan which is qualified under section 401(a), 403(a), or 405(a) of Title 26 (or with respect to which an application to so qualify has been filed and has not been finally determined) the Secretary may exercise his authority under subsection (a)(5) of this section with respect to a violation of, or the enforcement of, parts 2 and 3 of this subtitle (relating to participation, vesting, and funding), only if -

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[12] So in original. Probably should be "subtitle".

(A) requested by the Secretary of the Treasury, or

(B) one or more participants, beneficiaries, or fiduciaries, of such plan request in writing (in such manner as the Secretary shall prescribe by regulation) that he exercise such authority on their behalf. In the case of such a request under this paragraph he may exercise such authority only if he determines that such violation affects, or such enforcement is necessary to protect, claims of participants or beneficiaries to benefits under the plan.

(2) The Secretary shall not initiate an action to enforce section 1145 of this title.

(3) The Secretary is not authorized to enforce under this part any requirement of part 7 against a health insurance issuer offering health insurance coverage in connection with a group health plan (as defined in section 119lb(a)(1) of this title). Nothing in this paragraph shall affect the authority of the Secretary to issue regulations to carry out such part.

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form

(1) Any administrator (A) who fails to meet therequirements of paragraph (1) or (4) of section 1166 ofthis title or section 1021(e)(1) of this title with respect to a or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper. For purposes of this paragraph, each violation described in subparagraph (A) with respect to any single participant, and each violation described in subparagraph (B) with respect to any single participant or beneficiary, shall be treated as a separate violation.

(2) The Secretary may assess a civil penalty against any plan administrator of up to $1,000 a day from the date of such plan administrator's failure or refusal to file the annual report required to be filed with the Secretary under section 1021(b)(4) of this title. For purposes of this paragraph, an annual report that has been rejected under section 1024(a)(4) of this title for failure to provide material information shall not be treated as having been filed with the Secretary.

(3) Any employer maintaining a plan who fails to meet the notice requirement of section 1021(d) of this title with respect to any participant or beneficiary or who fails to meet the requirements of section 1021(e)(2) of this title with respect to any person may in the court's discretion be liable to such participant or beneficiary or to such person in the amount of up to $100 a day from the date of such failure, and the court may in its discretion order such other relief as it deems proper.

(4) The Secretary may assess a civil penalty of not more than $1,000 for each violation by any person of section 1021(f)(1) of this title.

(5) The Secretary may assess a civil penalty against any person of up to $1,000 a day from the date of the person's failure or refusal to file the information required to be filed by such person with the Secretary under regulations prescribed pursuant to section 1021(g) of this title.

(6) If, within 30 days of a request by the Secretary to a plan administrator for documents under section 1024(a)(6) of this title, the plan administrator fails to furnish the material requested to the Secretary, the Secretary may assess a civil penalty against the plan administrator of up to 8100 a day from the date of such failure (but in no event in excess of $1,000 per request). No penalty shall be imposed under this paragraph for any failure resulting from matters reasonably beyond the control of the plan administrator.

(7) The Secretary and the Secretary of Health and Human Services shall maintain such ongoing consultation as may be necessary and appropriate to coordinate enforcement under this subsection with enforcement under section 1.320b-14(c)(8) of Title 42.

(d) Status of employee benefit plan as entity

(1) An employee benefit plan may sue or be sued under this subchapter as an entity. Service of summons, subpena, or other legal process of a court upon a trustee or an administrator of an employee benefit plan in his capacity as such shall constitute service upon the employee benefit plan. In a case where a plan has not designated in the summary plan description of the plan an individual as agent for the service of legal process, service upon the Secretary shall constitute such service. The Secretary, not later than 15 days after receipt of service under the preceding sentence, shall notify the administrator or any trustee of the plan of receipt of such service.

(2) Any money judgment under this subchapter against an employee benefit plan shall be enforceable only against the plan as an entity and shall not be enforceable against any other person unless liability against such person is established in his individual capacity under this subchapter.

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

(2) Where an action under this subchapter is brought in a district court of the United States, it may be brought in the district where the plan is administered, where the breach took place, or where a defendant resides or may be found, and process may be served in any other district where a defendant resides or may be found.

(f) Amount in controversy; citizenship of parties.

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's ee —and costs of action to either party.

(2) In any action under this subchapter by a fiduciary for or on behalf of a plan to enforce section 1145 of this title in which a judgment in favor of the plan is awarded, the court shall award the plan -

(A) the unpaid contributions,

(B) interest on the unpaid contributions,

(C) an amount equal to the greater of -

(i) interest on the unpaid contributions,

or

(ii) liquidated damages provided for under the plan n an amount not in excess of 20 percent (or such higher percentage as may be permitted under Federal or State law) of the amount determined by the court under subparagraph (A),

(D) reasonable attorney's fees and costs of the action, to be paid by the defendant, and

(E) such other legal or equitable relief as the court deems appropriate.

For purposes of this paragraph, interest on unpaid contributions shall be determined by using the rate provided under the plan, or, if none, the rate prescribed under section 6621 of Title 26.

(h) Service upon Secretary of Labor and Secretary of the Treasury

A copy of the complaint in any action under this subchapter by a participant, beneficiary, or fiduciary (other than an action brought by one or more participants or beneficiaries under subsection (a)(1)(B) of this section which is solely for the purpose of recovering benefits due such participants under the terms of the plan) shall be served upon the Secretary and the Secretary of the Treasury by certified mail. Either Secretary shall have the right in his discretion to intervene in any action, except that the Secretary of the Treasury may not intervene in any action under part 4 of this subtitle. If the Secretary brings an action under subsection (a) of this section on behalf of a participant or beneficiary, he shall notify the Secretary of the Treasury.

(i) Administrative assessment of civil penalty

In the case of a transaction prohibited by section 1106 of this title by a party in interest with respect to a plan to which this part applies, the Secretary may assess a civil penalty against such party in interest. The amount of such penalty may not exceed 5 percent of the amount involved in each such transaction (as defined in section 4975(f)(4) of Title 26) for each year or part thereof during which the prohibited transaction continues, except that, if the transaction is not corrected (in such manner as

the Secretary shall prescribe in regulations which shall be consistent with section 4975(f)(5) of Title 26) within 90 days after notice from the Secretary (or such longer period as the Secretary may permit), such penalty may be in an amount not more than 100 percent of the amount involved. This subsection shall not apply to a transaction with respect to a plan described in section 4975(e)(1) of Title 26.

(j) Direction and control of litigation by Attorney General

In all civil actions under this subchapter, attorneys appointed by the Secretary may represent the Secretary (except as provided in section 518(a) of Title 28), but all such litigation shall be subject to the direction and control of the Attorney General.

(k) Jurisdiction of actions against the Secretary of Labor Suits by an administrator, fiduciary, participant, or beneficiary of an employee benefit plan to review a final order of the Secretary, to restrain the Secretary from taking any action contrary to the provisions of this chapter, or to compel him to take action required under this subchapter, may be brought in the district court of the United States for the district where the plan has its principal office, or in the United States District Court for the District of Columbia.

(l) Civil penalties on violations by fiduciaries
(1) In the case of -

(A) any breach of fiduciary responsibility under (or other violation of) part 4 of this subtitle by a fiduciary, or

(B) any knowing participation in such a breach or violation by any other person, the Secretary shall assess a civil penalty against such fiduciary or other person in an amount equal to 20 percent of the applicable recovery amount.

(2) For purposes of paragraph (1), the term "applicable recovery amount" means any amount which is recovered from a fiduciary or other person with respect to a breach or violation described in paragraph (1) -

(A) pursuant to any settlement agreement with the Secretary, or

(B) ordered by a court to be paid by such fiduciary or other person to a plan or its participants and beneficiaries in a judicial proceeding instituted by the Secretary under subsection (a)(2) or (a)(5) of this section.

(3) The Secretary may, in the Secretary's sole discretion, waive or reduce the penalty under paragraph (1) if the Secretary determines in writing that -

(A) the fiduciary or other person acted reasonably and in good faith, or

(B) it is reasonable to expect that the fiduciary or other person will not be able to restore all losses to the plan (or to provide the relief ordered pursuant to subsection (a)(9) of this section) without severe financial hardship unless such waiver or reduction is granted.

(4) The penalty imposed on a fiduciary or other person under this subsection with respect to any transaction shall be reduced by the amount of any penalty or tax imposed on such fiduciary or other person with respect to such transaction under subsection (i) of this section and section 4975 of Title 26.

(m) Penalty for improper distribution

In the case of a distribution to a pension plan participant or beneficiary in violation of section 1056(e) of this title by a plan fiduciary, the Secretary shall assess a penalty against such fiduciary in an amount equal to the value of the distribution. Such penalty shall not exceed $10,000 for each such distribution.

Supreme Court, U.S.
FILED
NOV 19 2007
OFFICE OF THE CLERK

No. 07-763

In The

Supreme Court of the United States

SHIRLEY A. GRAHAM,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY

Respondents.

Supplemental Appendix to
Petition For A Writ Of Certiorari
To The United States Court Of Appeals
For The Tenth Circuit

PETITION FOR A WRIT OF CERTIORARI

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Case 4:03-cv-00144-JOE-SAJ Document 21
Filed in USDC ND/OK on 04/22/2005

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY GRAHAM	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 03-CV-0144-JOE
	)	
HARTFORD LIFE INSURANCE COMPANY	)	
	)	
Defendant	)	

ORDER

The Court instructed both parties to submit briefs as to whether the Employment Retirement Security Act of 1974 (ERISA) is applicable to this case and, if so, whether ERISA preempts the state law claims asserted by the Plaintiff, Shirley Graham ("Graham").

Graham was employed for a number of years as a rural letter carrier by the United States Postal Service (USPS). As a USPS employee, Graham was a member of the National Rural Letter Carrier's Association (NRLCA), the official bargaining representative for rural letter carriers employed by the USPS. NRLCA's stated purpose is as follows: "The purpose of this Association shall be to improve the methods used by rural letter carriers, to benefit their conditions of labor with the United States Postal Service, and to promote fraternal spirit among its members." NRLCA has its own National Board and Executive Committee, has its own National Headquarters and maintains its own insurance department.

There exists a collective bargaining agreement (CBA) between USPS and NRLCA. Under the CBA, USPS is obligated to provide certain employee benefits to employees, including pension benefits, medical benefits and life insurance benefits. The CBA does not require USPS to provide a disability plan to members of the NRLCA.

Because USPS does not offer a disability benefit plan to rural letter carriers, NRLCA established a disability plan for those USPS employees who were NRLCA members. In a letter to its members, the NRLCA notified its members of the Plan and described it as follows:

> Dear Member,:
>
> The National Rural Letter Carriers' Association (NRLCA) is pleased to a offer long term disability income protection plan for its regular rural carrier (Designation 71) members.
>
> The disability income plan is designed to protect your most valuable asset, your income, in the event of a disabling illness or accident. Postal employees do not have a long term disability plan that is sponsored by the U.S. Postal Service. So the NRLCA has worked diligently over the past several years to develop and sponsor a disability plan for its regular carrier members.
>
> As a regular rural carrier, you now have the opportunity to enroll in a plan which provides affordable income protection coverage through the NRLCA. The Rural Letter Carrier Long Term Disability (RLCLTD) plan is entirely voluntary but we hope that you

> will seriously consider the benefits of this coverage and enroll NOW!!
>
> The Plan is sponsored by the NRLCA and underwritten by the Hartford Life and Accident Insurance Company..

In the same letter, NRLCA advised its members that they should direct any questions about the Plan to the NRLCA insurance department. The Plan enrollment form provides for NRCLA members to either request or decline coverage and to return the form, giving the return address of the "RLCLTD Plan Administrator, NRLCA Group Insurance Department, 1630 Duke Street, Alexandria, VA." The only involvement of the USPS with respect to the Plan is that members who enroll authorize automatic deductions from their wages in order to pay premiums.

The NRLCA, in order to provide disability benefits to members under the Plan, obtained a group long-term disability policy from Hartford. Under the group policy, NRLCA is the policyholder, and benefits are provided to the eligible class defined as, "All active full-time regular rural letter carrier (designation 71) members". Graham, as a member of the NRLCA, enrolled in the NRLCA Plan. She claims to be disabled and brought a claim under the Plan.

ERISA Preemption

ERISA comprehensively regulates, among other things, employee welfare benefit plans that, 'through the purchase of insurance or otherwise,' provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. *Pilot Life Ins. Co. V Dedeaux*, 481 U.S. 41, 44, 107 S. Ct. 1549, 95 L.Ed. 2d 39 (1987). The Supreme Court has expressly stated that ERISA's preemption provisions are "deliberately expansive." *Id* at 46, 107

S.Ct. 1549; see also *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98, 103 S.Ct. 2890, 77 L.Ed. 2d 490 (1983).

ERISA governs "employee benefit plan[s]."29 U.S.C.§1003(a). One form of employee benefit plan is an "employee welfare benefit plan." *Id. §1002(3).* An employee welfare benefit plan is:

> any plan, fund, or program ... established or maintained by an employer or by an employee organization ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance ... medical, surgical, or hospital care or benefits ... in the event of sickness, accident, disability,....*Id. §1002(1)*

The "preemption clause" (§514(a)) of ERISA provides that ERISA supercedes all state laws insofar as they "relate to any employee benefit plan." ERISA's "saving clause" (§514(b)(2)(A)) excepts from the preemption clause any state law that "regulates insurance". ERISA's "deemer clause" (§514(b)(2)(B)) provides that no employee benefit plan shall be deemed to be an insurance company for purposes of any state law "purporting to regulate insurance."

The main dispute in the present case is whether this particular plan is exempted from ERISA under the "government plan exclusion." Under 29 U.S.C. §1003(b)(1), "government plans" are excluded from the provisions of ERISA. A government plan is defined in 29 U.S.C. §1002(32) as:

The term "governmental plan" means a plan established or maintained for its employees by the Government of the United States, by the

Government of any state or political subdivision thereof or by any agency or instrumentality of any of the foregoing...

The Plaintiffs brief appears to assume that the union representing the rural carriers is one and the same as the USPS and then argues that it is obvious that the USPS is a part of the Government of the United States. The Court does not accept Plaintiffs argument and the Court finds that the disability plan in question does not meet the criteria to be a "government plan", and therefore, be excluded from ERISA constraints.

The Court finds the analysis of this issue in *Culpepper v. Protective Life Ins. Co.*, 938 F.Supp. 794, 798-800 (M.D. Ala. 1996) particularly persuasive. In *Culpepper*, the court adopted factors from NLRB cases and from the Internal Revenue Code to determine if the organization creating the plan could be considered a "political subdivision" of the state or federal government. "In determining whether an entity is a political subdivision under 29 U.S.C. § 1002(32), the court must consider whether the entity was `(1) created directly by the state, so as to constitute departments or administrative arms of the government, or (2) administered by individuals who are responsible to public officials or the general electorate' ". *Culpepper* at 798, citing *Rose v. Long Island R.R. Pension Plan*, 828 F.2d 910, 916 (2d. Cir 1987).

The *Culpepper* court also relied on six factors borrowed from the Revenue Ruling 57-128 of the Internal Revenue Service which determined whether an entity was a "political subdivision" under §414(d) of the Internal Revenue Code. *Culpepper* at 798.[1]

---

[1]The factors were: (1) whether it is used for a governmental purpose and performs a governmental function;

This Court finds that none of the tests applied by the Rose case or the Internal Revenue Code are satisfied in the present case.

The only significant fact that is present in Culpepper, which is not before this Court is that, in Culpepper, membership in the Alabama National Guard Association was purely voluntary and not a requirement to be employed with the National Guard. In the present case, it is unclear whether membership in the NRLCA was a requirement for employment. However, assuming that membership was required, the Court does not find that difference significant enough to change the Court's ruling. The union was formed for the benefit of its members and, often, the union's position would be in direct conflict with the employer. It is clear that employer did not control the union, did not support the union financially, and the union did not perform a governmental function. Therefore, the union plan does not qualify as a "government plan".

Bad Faith Claim

Because there is no question that the tort of insurance bad faith "relates to" the NRLCA's disability policies, which is an ERISA-regulated employee benefit plan, Graham's state law claim for

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(2) whether performance of its function is on behalf of one or more states or political subdivisions; (3) whether there are any private interests involved, or whether the states or political subdivisions involved have the powers and interests of an owner; (4) whether control and supervision of the organization is vested in public authority or authorities; (5) if express or implied statutory or other authority is necessary for the creation and/or use of such an instrumentality, and whether such authority exists; and (6) the degree of financial autonomy and the source of its operating expenses.

bad faith is preempted unless exempted from preemption by the saving clause. That clause exempts from preemption "any law ... which regulates insurance." 29 U.S.C.§1144(b)(2)(A). However, the Tenth Circuit has already ruled in *Gaylor v. John HancockMut. Life Ins. Co* 112 F.3 d 460 (10"' Cir.1997) , that the Oklahoma law of bad faith does not fall under the savings clause because it does "not regulate the spreading of policyholder risk". *Gaylor* at 466.

The civil enforcement provisions of ERISA §1132(a) were intended to be the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits, and Graham is restricted to that enforcement vehicle. Graham's state law claim for bad faith is hereby dismissed.

Within 45 days of the date of this Order, the parties shall submit to the Court the complete administrative record for the Court's review.

Dated this 22nd day of April, 2005.

/s/ James O. Ellison
James O. Ellison
U.S. District Judge

Case 4:03-cv-00144-CVE-SAJ Document 33
Filed in USDC DN/OK on 01/20/2006

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY A. GRAHAM,	
Plaintiff,	
vs.	**Case No. 03-CV-0144-CVE**
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,	
Defendant.	

OPINION AND ORDER

Plaintiff filed this action to recover benefits and to enforce her rights under the Employee Retirement Income Security Act of 1974,29 U.S.C. § 1101 et sue. ("ERISA"). Plaintiff challenges the decision by Hartford Life & Accident Insurance Company ("Hartford") to deny her claim for Long Term Disability ("LTD") benefits under her employer's group disability plan.

I.

Plaintiff was employed from November 1976 to July 2000 as a rural letter carrier by the United States Postal Service (USPS). Plaintiff was a member of the National Rural Letter Carrier's Association (NRLCA), the official bargaining representative for rural letter carriers employed by the USPS. The NRLCA, in order to provide benefits to members, obtained a group long-term disability policy from Hartford. As a member of the NRLCA, plaintiff became a participant in the Rural Letter

Carrier Long Term Disability Plan (the "Plan"). Administrative Record ("Adm. Rec.") at Hart-Graham 2-31 (subsequent references omit the Bates-stamp prefix). The NRLCA Plan is governed by ERISA. Dkt. # 21.

Plaintiff filed an application for LTD benefits on October 27, 2000. Her last day of work was July 15, 2000, when she reported that she became unable to work due to ankle surgery and ongoing problems with her ankles and knees. Plaintiff attributes her underlying injury to an on-the-job accident that occurred on February 7, 1994 while she was trying to get away from a dog. She began care with the Eastern Oklahoma Orthopedic Center on February 8, 1994. Since this initial injury, plaintiff has experienced multiple complications with her knees and ankles. She complains of chronic, moderately severe pain in both knees and weakness in both knees. She underwent surgery on her right knee on March 3, 1997, after which the USPS offered her a posit on as a Modified Rural Carrier, a sedentary job designed specifically to accommodate her physical condition. Adm. Rec. at 135. Plaintiff alleges that her condition worsened due to the development of osteoarthritis in both knees and both ankles. She argues that a decline in her health led to her retirement in 2000. On December 1, 2000, the United States Office of Personnel Management approved plaintiff for disability retirement. Id. at 240-41.

Upon receipt of plaintiffs claim, Hartford assigned a claims specialist who reviewed submitted documents and solicited additional materials from plaintiff, her primary orthopedic surgeon, Dr. Jeffrey Emel, and her employer. In a July 26, 2000 letter from Dr. Emel to the United States Department of Labor, he reported that "Mrs. Graham has significant osteoarthritis involving both knees and both ankles. An ambulatory job would be counterproductive for her.... I really do not think she

will be able to continue her work capacities and recommend that you consider her for Disability retirement." Id. at 81. The claims specialist contacted Dr. Emel to have him clarify whether plaintiff's condition affected her ability to perform a sedentary job and, on January 23, 2001, Dr. Emel responded that "no it does not but [the patient] has retired." Id. at 165. Based on this information, Hartford denied her claim in a letter dated February 28, 2001. Id. at 159-63.

Defendant contends that plaintiffs claim was denied because she failed to meet the policy definition of "total disability." According to the Plan, "total disability" means that the participant is unable, by reason of disability, to perform the essential duties of her occupation and as a result is earning less than 20% of her pre-disability earnings. Id. at 19. The Plan further requires a claimant to submit a "proof of loss" and states, "All proof submitted must be satisfactory to us." Adm. Rec. at 15. Under the Plan, Hartford is accorded "full discretion and authority to determine eligibility for benefits and to construe and interpret all terms and provisions of the Group Insurance Policy." Id. at 16. Hartford is both the payor and the claims administrator of the Plan.

In response to plaintiffs application for a review of the denial, Hartford assigned a new claims specialist to review the record as submitted by plaintiff. Dr. Emel wrote a letter dated March 7, 2001, stating that severe chondromalacia of the left knee prevented plaintiff from driving or sitting "for more than an hour at any one time." Id. at 133. Hartford did not enlist medical professionals to examine plaintiff or her medical records. The Hartford claim examiner noted that plaintiffs modified position with the USPS had been designed in 1997 to allow her to sit, elevate her feet, stand and walk as needed. Id. at 127-29. Finding that such

accommodation enabled plaintiff to perform the essential duties of her occupation, Hartford denied plaintiff's request for reconsideration on August 3, 2001. Id.

Plaintiff made a second appeal on September 26, 2001 of the decision to terminate her benefits. Id. at 125-26. During this stage of the appeals process, plaintiff supplemented the record with a personal letter describing her condition, but no further medical reports were submitted. Using a different appeal specialist, Hartford denied this appeal on November 27, 2001, again relying on the accommodation granted to plaintiff in 1997. Adm. Rec. at 74-76. Thereafter, plaintiff sought an additional review of her claim on February 21, 2003, but was informed that she had exhausted the appeals process. Id. at 38.

II.

On February 27, 2003, plaintiff filed suit, alleging defendant violated 29 U.S.C. § 1132 in denying her claim for benefits. As a plan beneficiary, plaintiff has the right to federal court review of benefit denials under ERISA. "ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans, and to protect contractually defined benefits." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989). Specifically, section 1132(a)(1)(B) grants plaintiff the right to bring a civil action to recover benefits or to enforce her rights under the terms of the Plan. A denial of benefits challenged under section 1132(a)(1)(B) is to be reviewed under an arbitrary and capricious standard when a plan gives the administrator or other fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of a plan. See Bruch, 489 U.S. at 115; Nance v. Sun Life Assurance Co. of Canada, 294 F.3d 1263, 1267-68 (10th Cir. 2002) (language that

claimant must submit "proof satisfactory to" insurer conferred discretion). The parties agree that the Plan gives Hartford such discretionary authority.

The issue, then, is whether defendant acted arbitrarily and capriciously when it made the final decision to deny plaintiffs claim for LTD benefits. Under the two-tier "sliding scale" approach adopted by the Tenth Circuit, an "additional reduction in deference is appropriate" where there is an inherent or proven conflict of interest. Fought v. Unum Life Ins. Co. of America, 379 F.3d 997, 1006 (10th Cir. 2004). It is undisputed that Hartford has an inherent conflict of interest as it is both payor and claims administrator of the Plan. As such, there is a reduction in deference to the administrator's decision and Hartford "bears the burden of proving the reasonableness of its decision." Id.

Hartford "must establish by substantial evidence that its denial of benefits was reasonable." Fought, 379 F.3d at 1014. "Substantial evidence is such evidence that a reasonable mind might accept as adequate to support the conclusion reached by the [decisionmaker]. Substantial evidence requires more than a scintilla but less than a preponderance." Sandoval v. Aetna Life and Cas. Ins., Co., 967 F.2d 377, 382 (10th Cir. 1992) (internal citations and quotation marks omitted). The Court considers the record as a whole. Caldwell v. Life Ins. Co. of North America, 287 F.3d 1276, 1282 (10th Cir. 2002). However, the Court considers only that information available to the plan administrator at the time the decision was made. Hall v. Unum Life Ins. Co. of Am., 300 F.3d 1197, 1201 (10th Cir. 2002). Therefore, the materials plaintiff submitted with her purported third appeal after the final denial on November 27, 2001 are not properly part of the record.

The Court must "take into account whatever

in the record fairly detracts from the weight of the evidence in support of the administrator's decision." Washington v. Shalala, 37 F.3d 1437, 1439 (10th Cir. 1994) (internal citations and quotation marks omitted). "Evidence is not substantial `if it is overwhelmed by other evidence -- particularly certain types of evidence (, that offered by treating physicians), or if it really constitutes not evidence but mere conclusion.'" Knipe v. Heckler, 755 F.2d 141, 145 (10th Cir. 1985) (citation omitted). The Court gives less deference to an administrator's conclusions if the administrator fails to gather or examine relevant evidence. See Caldwell, 287 F.3d at 1282. Yet, the Court "will not set aside a [] decision if it was based on a reasonable interpretation of the plan's terms and was made in good faith." Trujillo v. Cyprus Amax Minerals Co., Ret. Plan Comm., 203 F.3d 733, 736 (10th Cir. 2000).

III.

The Court finds that Hartford's decision to deny plaintiff's claim for LTD benefits was arbitrary and capricious. Hartford has not met its burden of proving the reasonableness of its decision by substantial evidence. Hartford referenced, as the basis for its determination, the 1997 accommodation for plaintiffs disability and Dr. Emel's January 23, 2001 statement that plaintiff's medical condition "does not" restrict her from work. By relying on the 1997 USPS accommodation to justify the denial, Hartford suggests that once an individual requests and receives accommodation for a disability, she foregoes future eligibility for LTD benefits. Hartford undertook no independent medical review of changes in plaintiffs condition between the accommodation in 1997 and her retirement in 2000. Absent additional evidence, prior accommodation does not amount to substantial evidence on which to base a denial of LTD benefits. See Hawkins v. First Union Core, Long-Term Disability Plan, 326 F.3d 914, 918 (7th

Cir. 2003) ("A disabled person should not be punished for heroic efforts to work by being held to have forfeited his entitlement to disability benefits should he stop working").

Further, Hartford's reliance on Dr. Emel's January 23, 2001 statement, which favors their decision, ignores his July 26, 2000 statement that plaintiff is disabled and his March 7, 2001 statement that she is incapable of sitting for more than one hour. The record suggests that Hartford gave undue weight to the January 23, 2001 statement. See Black & Decker Disability Plan v. Nord, 538 U.S. 822, 834 (2003) ("Plan administrators, of course, may not arbitrarily refuse to credit a claimant's reliable evidence . . ."). In addition, while independent medical examinations are not required to establish reasonableness, "[w]here, as here, a conflict of interest may impede the plan administrator's impartiality, the administrator best promotes the purposes of ERISA by obtaining an independent evaluation." Fought, 379 F.3d at 1015; see Gaither v. Aetna Life Ins. Co., 388 F.3d 759, 773 (10th Cir. 2004) ("fiduciaries cannot shut their eyes to readily available information when the evidence in the record suggests that the information might confirm the beneficiary's theory of entitlement and when they have little or no evidence in the record to refute that theory.").

IV.

In summary, defendant failed to establish by substantial evidence that its denial of benefits was reasonable. Viewing the record as a whole, defendant failed to offer "more than a scintilla" of evidence to support its denial. Sandoval, 967 F.2d at 382. The Court finds that defendant's decision to deny plaintiffs claim for LTD benefits was arbitrary and capricious.

IT IS THEREFORE ORDERED that defendant's November 27, 2001 final decision to deny plaintiffs claim for LTD benefits is hereby **REMANDED** to the Plan administrator for a full and fair redetermination of the claim.

DATED this 20th day of January, 2006.

/s/ Claire V. Eagan
Claire V. Eagan
U.S. District Judge

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Filed in USDC ND/OK on 01/20/2006

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY A. GRAHAM,	)
	)
Plaintiff,	)
	)
vs.	)**Case No 03-CV-**
	)**0144-CVE**
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,	)
	)
Defendant.	)

JUDGMENT

This action has come before the Court for consideration and an Opinion and Order (Dkt. # 33) has been entered remanding the decision of defendant, Hartford Life & Accident Insurance Company, as administrator of the Long-Term Disability Plan (the "Plan").

Pursuant to the Court's Opinion and Order, judgment is hereby entered remanding the case to the Plan administrator for a full and fair redetermination of the claim.

DATED this 20th day of January, 2006.

/s/ Claire V. Eagan
Claire V. Eagan
U.S. District Judge

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY A. GRAHAM,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	Case No. 03-CV-0144-CVE
	)	
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,	)	
	)	
	)	
Defendant.	)	

REPORT AND RECOMMENDATION

Comes on for Report and Recommendation Plaintiffs Application for Attorney Fees Pursuant to 29 U.S.C. §11 32(g)(1) [Dkt.#35-1] in which Plaintiff seeks attorney fees against Defendant in the amount of $22,230.00. Having considered the arguments and authorities presented by the parties, the undersigned recommends that Plaintiffs motion for attorney fees be denied.

I. BACKGROUND AND PROCEDURAL HISTORY

Plaintiff filed this action on February 27, 2003, alleging breach of the duty of good faith and fair dealing, and seeking actual and punitive damages arising from Defendant's denial of Plaintiffs claim that she was entitled to long term disability insurance payments. Plaintiff was originally represented by attorneys Mike Jones and Alan Souter.

On April 15, 2004, after several continuances of the initial status conference requested bythe parties, Judge James O. Ellison held initial status conference and ordered

simultaneous briefs to be filed on July 29, 2004, on the applicability of ERISA to Plaintiffs claims. That same day, attorney Joseph F. Clark entered an appearance in the case on behalf of Plaintiff. The Court also entered a scheduling order allowing limited discovery based upon the briefing date. The minute order following the initial status conference stated that once these issues were resolved, the parties would submit an additional joint status report and a scheduling order would be entered as appropriate.

The Court entered an Order on April 22, 2005, finding that Plaintiffs claim was subject to ERISA and her state law claim for bad faith was therefore preempted. Accordingly, this claim was dismissed. The Order further provided a schedule under which the parties were to submit the complete administrative record for the Court's review. A briefing schedule followed.

On October 3, 2005, the case was reassigned to Judge Claire V. Eagan and on January 20, 2006, Judge Eagan entered an Order remanding the case to the Plan Administrator for a full and fair redetermination of the claim.

On February 3, 2006, Plaintiff filed the pending motion which was referred to the undersigned.

II. REQUEST FOR ATTORNEY FEES

Plaintiff requests attorney fees pursuant to 29 U.S.C. § 11 32(g)(1) which provides that "in any action under this subchapter ... by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party." 29 U.S.C. § 1132(g)(1). This is not a prevailing party statute and the award is discretionary with the Court.

The Tenth Circuit Court of Appeals in *Gordon v. United States Steel Corp.*, 724 F.2d 106 (10th Cir. 1983), provides guidance as to when an award of attorney fees is appropriate. Five non-exhaustive factors are to be evaluated as follows:

> [W]hen determining whether to award attorney's fees under section 1132(g)(1), the district court should consider these factors among others: (1) the degree of the opposing parties' culpability or bad faith; (2) the ability of the opposing parties to personally satisfy an award of attorney's fees; (3) whether an award of attorney's fees against the opposing parties would deter others from acting under similar circumstances; (4) whether the parties requesting fees sought to benefit all participants and beneficiaries of an ERISA plan or to resolve a significant legal question regarding ERISA; and (5) the relative merits of the parties' positions.

Gordon, 724 F.2d at 108.

Applying these to the case at bar, the record does not indicate that Defendant acted in bad faith nor did the District Court so find. Rather, the District Court concluded that Defendant's actions were arbitrary and capricious because the decision was not supported by substantial evidence. Plaintiff argues that under Oklahoma insurance law, a judgment would have appropriately been rendered for breach of the obligation of good faith and fair dealing. There is nothing before this Court to substantiate that claim.

As to the second factor, there is no discussion regarding the ability of the Defendant to pay. In regard to the third factor, the fact that an

administrator erred in one case will not necessarily serve as a deterrent to other administrators.

The fourth factor is whether the parties requesting the fees sought to benefit all participants or resolve a significant legal question regarding ERISA. Plaintiffs lawsuit appears primarily directed to impact Plaintiffs benefits.

The fifth factor is the relative merits of the parties' positions. This weighs in favor of Plaintiff. However, it is important to note the District Court did not make an outright award to Plaintiff. Rather, the case was remanded. Case law indicates fees are generally not awarded in a remanded action where there is no definitive finding of bad faith in spite of actions by a defendant which are more egregious than the actions of this Defendant. *See e.g., Lewis v. ITT Hartford Life & Accident Ins. Co.*, 395 F. Supp 1053 (D. Kan. 2005); *Krogh v. Chamberlain*, 708 F. Supp. 1235(D.Utah 1989). The same result can be found where outright benefits were conferred. *Britton v. Long Term Disability Ins. Plan of the Lovelace Inst.*, 217 F. Supp. 2d 1207 (D. N.M. 2002). Accordingly, this Court recommends no attorney fees be awarded herein pursuant to *Gordon*.

The Court finds this recommendation is further supported by Defendant's assertion that Plaintiffs fee application should be denied, or in the alternative, reduced based upon Plaintiff having failed to meet her burden of proof. The Court agrees, concluding that even if Plaintiff succeeded in establishing entitlement under *Gordon*, Plaintiffs application fails on this ground.

An award of attorney fees is the product of a reasonable number of hours expended on the litigation multiplied by a reasonable hourly rate which results in the lodestar calculation. *Burk v. City of Oklahoma City*, 598 P.2d 659 (Okla. 1979). It

is the Plaintiffs burden to establish entitlement to fees and reasonableness of both hours and hourly rate. *Beard v. Teska*, 31 F.3d 942 (10"' Cir. 1994).

Plaintiff has submitted only a two page exhibit containing time entries totaling 74.10 hours at a billable rate of $300 per hour. The verification at the bottom of page two simply states the entries represent the actual time spent on the [referenced] work according to the time records kept by Joseph F. Clark, Jr. There is no evidence from which this Court can ascertain whether the rate of $300 an hour is in line with those prevailing in the community for similar services by lawyers of comparable skill, experience, and reputation. *Ellis v. University of Kansas Medical Center*, 163 F.3d 1186 (10t" Cir. 1999), citing *Malloy v. Monahan*, 73 F.3d 1012 (10th Cir. 1996). Additionally, there is nothing in the record from which the Court can determine how long counsel has practiced, whether his practice is concentrated in this and/or other areas of law, or what reputation he has within the legal community. Even if he had provided sufficient information establishing his customary rate is $300, which he did not, or that $300 is the rate he charged this client, these factors would fall short of the required proof.

Further, Plaintiff had the right and the opportunity to rectify the deficiencies in his application by filing a reply brief pursuant to N.D.LCvR 7.2(h). Plaintiff did not file a reply brief nor timely request additional time within which to file reply brief.

Ill. RECOMMENDATION

The undersigned recommends Plaintiffs Application for Attorney Fees Pursuant to 29 U.S.C. §1132(g)(1) [Dkt.#35-1] be denied for the reasons stated herein.

IV. OBJECTIONS

In accordance with 28 U.S.C. § 636(b) and Fed. R. Civ. P. 72(b), a party may file specific written objections to this Report and Recommen lation. Objections must be filed with the Clerk of the District Court for the Northern District of Oklahoma within 10 days of being served with a copy of this Report and Recommendation. See Fed. R. Civ. P. 6 (as to computation of time periods). If specific written objections are timely filed, the district judge assigned to this case will

> make a *de novo* determination upon the record, or after additional evidence, of any portion of the magistrate judge's disposition to which specific written objection has been made in accordance with this rule. The district judge may accept, reject, or modify the recommended decision, receive further evidence, or recommit the matter to the magistrate judge with instructions.

Fed. R. Civ. P. 72(b). *See also* 28 U.S.C. § 636(b)(1).

The Court of Appeals for the Tenth Circuit has adopted a "firm waiver rule" in connection with appeals from orders adopting a Magistrate Judge's report and recommendation. "[T]he failure to make timely objections to the magistrate's findings or recommendations waives appellate review of factual and legal questions." *United States v. One Parcel of Real Property*, 73 F.3d 1057, 1059 (10th Cir. 1996) (quoting *Moore V. United States*, 950 F.2d 656, 659 (10th Cir. 1991)). **Thus, a timely, specific and written objection is necessary to preserve an issue for de novo review by the assigned district judge and for appellate review by the court of appeals**. *See Thomas v. Am*, 474 U.S. 140 (1985); *Haney v. Addison*, 175 F.3d 1217 (10th Cir. 1999); and *Talley*

v. Hesse, 91 F.3d 1411 (10th Cir. 1996).

DATED THIS 22nd DAY OF May 2006.

/s/ Sam A. Joyner
Sam A. Joyner
United States Magistrate Judge

Case 4:03-cv-00144-CVE-SAJ Document 46 Filed in USDC ND/OK on 06/28/2006

UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF OKLAHOMA

SHIRLEY A. GRAHAM,	)
	)
Plaintiff,	)
	)
vs.	)Case No. 03-CV-
	)0144-CVE
HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,	)
	)
Defendant.	)

OPINION AND ORDER

On May 22, 2006, Magistrate Judge Sam A. Joyner entered a Report and Recommendation (Dkt. # 43) on plaintiffs Application for Attorney's Fees (Dkt,# 35). Magistrate Judge Joyner recommended that the Court exercise its discretion to deny plaintiff's motion for attorney's fees. See 29 U.S.C. § 1132(g)(1). Plaintiff fled an objection to the Report and Recommendation (Dkt. # 44) pursuant to 28 U.S.C. § 636(b) and Fed. R. Civ. P. 72(b). Rule 72(b) provides that "the district judge to whom the case is assigned shall make a *de novo* review determination upon the record, or after additional evidence."

Accordingly, the Court has conducted a *de novo* review. The Court may accept, reject, or modify the report and recommendation of the Magistrate Judge in whole or in part. For reasons set forth below, the Magistrate Judge's Report and Recommendation (Dkt. # 43) shall be adopted in its entirety.

Plaintiff seeks attorney's fees pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1101 et seq. ("ERISA"). ERISA provides, in relevant part:

> in any action under this subchapter ... by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

29 U.S.C. § 1132(g)(1). This is not a prevailing party statute. In determining whether to award attorney's fees, the Court may consider: evidence of bad faith; the ability of the opposing party to satisfy an award of attorney's fees; whether an award of fees would deter others from future wrongdoing; whether the party requesting fees sought to benefit all participants of an ERISA plan or to resolve a significant legal question regarding ERISA; and the relative merits of the parties' positions. *Gordon v. United States Steel Core.*, 724 F.2d 106, 108 (10th Cir. 1983). The Court considers all five factors articulated in Gordon and finds that each party to this action shall be responsible for its own attorney's fees.

Upon finding that defendant's final decision to deny plaintiff's claim for long term disability benefits was arbitrary and capricious, the Court remanded this case to the administrator of the Rural Letter Carrier Long Term Disability Plan for a full and fair redetermination of the claim. Dkt. # 33. There was no finding of bad faith. Plaintiffs conclusory allegations of defendant's bad faith do not support such a finding. Plaintiff asks the Court to adopt the view that an arbitrary and capricious decision amounts to bad faith. However, these types of

conduct are not identical.[1] In holding that defendant's final denial of plaintiff's claim was arbitrary and capricious, the Court found that defendant lacked substantial evidence to support its conclusion. The Court did not attribute any intent or malice to defendant's decision. Attorney's fees are generally not awarded in a remanded action where there is no definitive finding of bad faith. See e.g., *Lewis v. ITT Hartford Life & Accident Ins. Co.*, 395 F. Supp. 2d 1053, 1065 (D. Kan. 2005).

Defendant concedes that it can afford to satisfy an award of attorney's fees. Further, an award of attorney's fees may deter other administrators from making determinations on disability benefit applications absent substantial evidence. However, these two factors of the Gordon test are not sufficient to merit attorney's fees for plaintiff. The decision of whether to award attorney's fees remains within the discretion of the Court.

Plaintiff did not seek to benefit all participants and beneficiaries of an ERISA plan. Instead, plaintiff pursued this claim specific to her individual claim for long term disability benefits. More importantly, while defendant failed to properly support its decision below, the record does not suggest that plaintiffs claim for benefits is particularly

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[1] "Arbitrary" and "capricious" relate to impulsiveness. Merriam Webster's Collegiate Disctionary, 10th Ed.(1994). These attributes indicate a lack of thorough review and may evidence only negligence. This standard does not equate to bad faith. See Badillo v. Mid Century Ins. Co., 121P.3d 1080, 1094 (Okla. 2005) ("the minimum level of culpability necessary for liability against an insurer to attach is more than simple negligence, but less than the reckless conduct necessary to sanction a punitive damage award against said insurer.").

meritorious. Plaintiff sought "judgment against [defendant] for breach of its duty of good faith and fair dealing, actual damages in an amount in excess of the sum specified by 28 U.S.C. § 1332, exclusive of interest and costs, pain ive damages in an amount in excess of the sum specified by 28 U.S.C. § 1332, exclusive of interest and costs, attorney fees, interest, court costs, and for such other and further relief as this Court deems equitable and proper." Dkt. # 1, at 3. Plaintiff did not prevail on this request. Dkt. # 21 (dismissing plaintiff's bad faith claim). The Court did not hold that "it would be unreasonable for the plan administrator to deny the application for benefits on any ground." See Caldwell v. Life Ins. Co. of North America, 287 F.3d 1276, 1289 (10th Cir. 2002) (citations omitted).

Accordingly, the Court did not award plaintiff disability benefits or compensation, but rather remanded the case for a full and fair reconsideration.

Based on a careful review of the Report and Recommendation, plaintiffs objection, defendant's response, and an independent review of the record and the relevant authorities, the Court finds that the Report and Recommendation (Dkt. # 43) is hereby **adopted**.

IT IS THEREFORE ORDERED that plaintiffs objection to the Report and Recommendation (Dkt. # 44) is **overruled** and plaintiffs Application for Attorney's Fees (Dkt. # 35) is **denied**.

DATED this 28th day of June, 2006.

/s/ Claire V. Eagan
Claire V. Eagan, Chief Judge
United States District Court

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(3)

No. 07-768

IN THE

Supreme Court of the United States

SHIRLEY A. GRAHAM,

Petitioner,

v.

HARTFORD LIFE & ACCIDENT INSURANCE COMPANY,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Tenth Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Whether the court of appeals erred in holding that the district court order remanding petitioner's disability-benefits claim to the plan administrator for a "full and fair redetermination" was not a final order appealable under 28 U.S.C. § 1291.

STATEMENT PURSUANT TO RULE 29.6

Respondent Hartford Life & Accident Insurance Company is a non-publically traded company that is wholly owned by Hartford Life, Inc.

Hartford Life, Inc. is a non-publically traded company that is wholly owned by Hartford Holdings, Inc.

Hartford Holdings, Inc. is a non-publically traded company that is wholly owned by The Hartford Financial Services Group, Inc., which is publically traded on the New York Stock Exchange.

Hartford Life, Inc., Hartford Holdings, Inc., and The Hartford Financial Services Group, Inc. are all holding companies.

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INTRODUCTION

Respondent Hartford Life & Accident Insurance Company submits this brief in opposition to the petition for a writ of certiorari filed by Shirley A. Graham. Contrary to petitioner's claims, the courts of appeals are not in disarray over the appealability of orders in ERISA cases that remand benefit determinations to plan administrators for further proceedings. Instead, there is a single outlier decision, rendered over eight years ago by the Seventh Circuit, that has had only limited impact in the Seventh Circuit itself, and has been rejected by every court of appeals that has considered its reasoning since. There is thus no reason to address the question petitioner raises unless and until the Seventh Circuit is given a chance to re-visit the issue and to decide whether it will adhere to a now widely repudiated view it expressed in a 1999 decision.

In all events, this case is a poor vehicle for addressing that question. Petitioner seeks a ruling on the appealability of ERISA remand orders in a case in which her principal claim is that ERISA does not apply at all. Petitioner could have sought review of that controlling legal question, however, without regard to the appealability of remand orders in ERISA cases, by simply moving for interlocutory review under 28 U.S.C. § 1292(b). Having declined to do so, she should not be permitted to use a minor conflict unique to ERISA to appeal an order she claims should never have been decided under ERISA in the fist place. Accordingly, the petition should be denied.

COUNTER STATEMENT OF THE CASE

1. Petitioner Shirley Graham worked as a rural letter carrier for the United States Postal Service from 1976 until 2000. Supplemental Appendix to Petition for a Writ of Certiorari ("Sup. Pet. App.") at 49a. She was also a member of the National Rural Letter Carrier's Association ("NRLCA"), the official bargaining representative for rural letter carriers employed by the Postal Service. *Id.* Because the Postal Service did not offer a disability-benefits plan to rural letter carriers, the NRLCA established its own plan and obtained a group long-term disability policy for its members from respondent Hartford Life & Accident Insurance Company. *Id.* at 43a.

Petitioner's health problems began in February 1994, when she twisted her knee and was forced to undergo arthroscopic surgery. Sup. Pet. App. at 50a. Although petitioner later returned to work, her condition deteriorated, prompting her first to accept a sedentary position in 1997 and eventually to retire in mid-2000. *Id.* Petitioner filed a claim for long-term disability benefits with respondent in October 2000, approximately three months after retiring. *Id.* Respondent denied petitioner's claim and rejected each of her three appeals. *Id.* at 50a-52a.

2. In February 2003, petitioner filed suit under the district court's diversity jurisdiction alleging that respondent breached its duty of good faith and fair dealing under Oklahoma law. Appendix to Petition for a Writ of Certiorari ("Pet. App.") at 4a-5a. The district court ordered the parties to brief whether the Employee Retirement Income Security Act ("ERISA") applied to the suit. Sup. Pet. App. at 42a. In April 2005, the court rejected petitioner's contention that the disability-benefits plan offered by the NRLCA was exempt from ERISA under the "government plan

exclusion," 29 U.S.C. § 1003(b)(1). *Id.* at 47a. The court then concluded that ERISA preempted petitioner's state-law claims and ordered the parties to file a copy of the administrative record. *Id.* at 48a. Petitioner sought neither reconsideration of the district court's ruling nor certification of the issue for interlocutory appeal.

The district court held that respondent's decision denying the benefits claim had been arbitrary and capricious. Sup. Pet. App. at 54a. Applying the Tenth Circuit's decision in *Fought v. UNUM Life Ins. Co. of Am.*, 379 F.3d 997, 1006 (2004), the court began by finding that respondent operated under a conflict of interest as the claims administrator and the insurer of benefits. Sup. Pet. App. at 53a. Shifting the burden to respondent to establish that its decision was reasonable, *id.*,[1] the court ruled that respondent had not met its burden because it (1) had relied on petitioner's ability to work in a sedentary post first designed for her three years before she retired; (2) had given excessive weight to one statement by her treating physician while undervaluing other assessments; and (3) had failed to use an independent medical evaluation to resolve conflicting evidence. *Id.* at 54a-55a. But the court

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[1] This Court recently granted certiorari to consider both whether a claims administrator who also funds the ERISA plan operates under a conflict of interest and, if so, how that conflict should be taken into account on judicial review of a discretionary benefits determination. *Metro. Life Ins. Co. v. Glenn*, No. 06-923 (U.S. Jan. 18, 2008) (order granting Petition for a Writ of Certiorari). The Tenth Circuit is one of only two courts of appeals to shift to a plan admininstrator operating under a presumed conflict the burden of demonstrating the reasonableness of its decision. *See* Brief for United States as *Amicus Curiae* at 10, *Metro. Life Ins. Co. v. Glenn*, No. 06-923 (U.S. filed Dec. 21, 2007).

did not award benefits to petitioner, nor did it make any decision on whether petitioner was entitled to benefits. The court instead remanded the case with instructions that respondent undertake "a full and fair redetermination of the claim." *Id.* at 56a-57a.

Petitioner then moved for an award of attorney fees under 29 U.S.C. § 1132(g)(1). Affirming a report and recommendation from the magistrate judge, Sup. Pet. App. at 58a-64a, the district court denied petitioner's motion. *Id.* at 68a. The court observed that it had made no finding that respondent had acted in bad faith. *Id.* at 66a. Nor had it concluded that petitioner's "claim for benefits [wa]s particularly meritorious." *Id.* at 67a-68a. Indeed, the court noted that no decision has been made on the merits, and that it had specifically declined to hold "that 'it would be unreasonable for the plan administrator to deny the application for benefits on any ground.'" *Id.* at 68a (quoting *Caldwell v. Life Ins. Co. of N. Am.*, 287 F.3d 1276, 1289 (10th Cir. 2002)). Petitioner appealed both the order remanding for a full and fair determination and the order denying her motion for attorney fees. The two appeals were consolidated before the Tenth Circuit.

3. The court of appeals dismissed the appeal for lack of jurisdiction. Applying the definition of finality long ago articulated by this Court, Pet. App. at 9a, the court of appeals held that the remand order was not "final" and therefore was not appealable under 28 U.S.C. § 1291. The court "declined to adopt a hard-and-fast rule regarding whether a district court's order remanding a benefits determination to a plan administrator is final," *id.* at 10a, and instead considered whether rejecting an immediate appeal in this case "would violate basic judicial principles" and foreclose appellate review of "urgent and important"

issues. *Id.* at 11a-12a (internal quotation marks omitted). There was nothing "'urgent'" about the remand order here, the court concluded, because petitioner might well prevail on remand; she could challenge a renewed denial in the district court, with review available in the court of appeals; and she could renew her contention that ERISA did not apply to her suit following the proceedings on remand. *Id.* at 14a-16a. The court recognized that other circuits had taken slightly different approaches to the question of finality, but pointed out that petitioner "would fare no better" under all but one of those approaches. *Id.* at 17a-21a.

Finally, the court of appeals vacated the district court's denial of petitioner's motion for attorney fees, concluding that the motion was not ripe for resolution. The district court could not properly apply the test for awarding fees, the panel reasoned, without knowing whether petitioner was entitled to benefits under the plan and what impact the litigation would have on other beneficiaries. Pet. App. at 25a. Accordingly, the court instructed the district court to dismiss the motion without prejudice to refiling.

REASONS FOR DENYING THE PETITION

In seeking review of the lower court's jurisdictional ruling, petitioner mistakenly suggests that the courts of appeals are in disarray over the appealability of an order remanding an ERISA benefits claim to a plan administrator for further proceedings. In fact, all but one of the seven courts of appeals to address the issue treat ERISA remand orders as nonfinal, and thus not immediately appealable, unless the orders satisfy the collateral-order doctrine or a variant of that test. The lone exception is the Seventh Circuit, whose divided

1999 decision equating remands in the ERISA context with remands in Social Security cases has been rejected by the three courts of appeals to have considered it in the intervening eight years. There is no pressing need for review of that decision, which has had only limited impact in the Seventh Circuit itself, and this case is an inappropriate vehicle for resolving any tension created by the Seventh Circuit's solitary approach.

Indeed, petitioner asks this Court to decide the appealability of ERISA remand orders in a case in which her primary contention is that ERISA does not apply at all. It makes little sense to resolve a minor conflict unique to ERISA law in a case where petitioner seeks to invoke appellate jurisdiction in the hopes of establishing that the statute on which such jurisdiction is predicated does not apply. This is especially true given that the answer to the question presented would not necessarily hasten the disposition of the case. Petitioner's focus on the supposed inequities created by the prevailing jurisdictional rule is likewise unavailing, since the rule that she assails applies equally to bar challenges by plan administrators to remand orders favoring claimants. Finally, the specter of delay invoked by petitioner rings hollow in this case, where the benefits may well have already been paid had petitioner not appealed to the Tenth Circuit or sought review in this Court in an effort to revive her claim for compensatory and punitive damages.

I. ANOTHER CIRCUIT'S DIFFERING APPROACH TO DECIDING THE FINALITY OF ERISA REMAND ORDERS DOES NOT WARRANT REVIEW AT THIS TIME.

Petitioner's principal argument in support of certiorari is that the courts of appeals are divided on

the question of "when an ERISA remand order is a final appealable order." Pet. at 6, 15-16, 24, 33.[2] Although there are slight differences in the way the circuits assess the finality of ERISA remand orders, petitioner mischaracterizes the nature and extent of those differences and overlooks the fact that six of the seven courts of appeals to address the issue generally deem such orders nonfinal. Neither the contrary ruling from one court nor the silence of the remaining regional circuits favors review in this case.

A. The Vast Majority Of The Courts Of Appeals Treat ERISA Remand Orders As Nonfinal Decisions Immediately Appealable Only Under The Collateral-Order Doctrine Or A Close Analogue.

A district court decision is "final," and thus appealable under 28 U.S.C. § 1291, where that decision "ends the litigation on the merits and leaves nothing for the court to do but execute the judgment." *Cunningham v. Hamilton County, Ohio*, 527 U.S. 198, 204 (1999) (internal quotation marks omitted). The Court has adhered to this definition for over sixty years, *see Catlin v. United States*, 324 U.S. 229, 233 (1945), declining to carve out exceptions that could "overpower the substantial finality interests

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[2] Petitioner also argues that the circuits have divided over "when remand to a Plan Administrator would be appropriate." Pet. at 6. But petitioner identifies no cases exhibiting such a split, and remand remains a widely accepted remedy. The courts of appeals agree, for example, that remand to the plan administrator is the appropriate remedy where the problem arises from the integrity of the plan's decisionmaking process, rather than from the plan's denial of benefits to which a claimant is clearly entitled. *See, e.g., Elliott v. Metro. Life Ins. Co.*, 473 F.3d 613, 622 (6th Cir. 2006); *Buffonge v. Prudential Ins. Co. of Am.*, 426 F.3d 20, 31-32 (1st Cir. 2005).

§ 1291 is meant to further." *Will v. Hallock*, 546 U.S. 345, 350 (2006).

Adhering to this Court's settled interpretation of finality, most courts of appeals to consider the question have held a district court's order remanding a benefits claim to an ERISA plan administrator for further proceedings to be nonfinal. *See Petralia v. AT&T Global Info. Solutions Co.*, 114 F.3d 352, 354 (1st Cir. 1997); *Bowers v. Sheet Metal Workers Nat'l Pension Fund*, 365 F.3d 535, 536 (6th Cir. 2004); *Shannon v. Jack Eckerd Corp.*, 55 F.3d 561, 563 (11th Cir. 1995) (per curiam); *see also Borntrager v. Cent. States, Se. & Sw. Areas Pension Fund*, 425 F.3d 1087, 1091 (8th Cir. 2005) (reaching same conclusion outside of benefits context). These courts have reasoned that, rather than leaving nothing to be done except execution of the judgment, an order remanding to the plan administrator *mandates* further proceedings and often additional findings. *See Petralia*, 114 F.3d at 354; *Shannon*, 55 F.3d at 563. Remand orders also fail to resolve definitively the amount of damages or other relief to which a claimant may be entitled. Courts have consequently concluded that remand orders do not qualify as "final" under this Court's decision in *Liberty Mutual Insurance Co. v. Wetzel*, 424 U.S. 737, 744 (1976), which established that district court orders leaving the "assessment of damages or awarding of other relief . . . to be resolved" are not "'final' within the meaning of 28 U.S.C. § 1291." *See Bowers*, 365 F.3d at 536; *see also Rekstad v. First Bank Sys., Inc.*, 238 F.3d 1259, 1262 (10th Cir. 2001).

Because ERISA remand orders typically do not end the litigation, the remaining question is whether those orders are nevertheless appealable on another ground. The First, Eighth, and Eleventh Circuits

have evaluated the appealability of ERISA remand orders under the collateral-order doctrine. *Petralia*, 114 F.3d at 354; *Borntrager*, 425 F.3d at 1092; *Shannon*, 55 F.3d at 563-64. Applying the "'stringent'" conditions of this doctrine, *Will*, 546 U.S. at 349, the First and Eleventh Circuits have declined to exercise collateral-order jurisdiction over orders remanding to an ERISA plan adminstrator for a fresh determination of the claimant's eligibility for benefits. The eligibility question, those courts explained, is not collateral to, but is instead at "the very heart of" (or "inextricably intertwined with the merits of") the decision to remand. *Petralia*, 114 F.3d at 354; *Shannon*, 55 F.3d at 563. Nor does a remand order either conclusively establish a claimant's entitlement to benefits or foreclose review of the entitlement question on appeal from the final judgment entered by the district court. The Eighth Circuit has reached the same conclusion outside of the benefits-denial context. *Borntrager*, 425 F.3d at 1092-93 (finding no collateral-order jurisdiction over a district court order remanding for further development of the record and additional discovery in a company's suit alleging wrongful expulsion from a multi-employer pension fund).

Two other courts of appeals—the Ninth and Tenth Circuits—apply a somewhat more permissive version of the collateral-order doctrine. *See* Pet. App. at 11a; *Hensley v. Nw. Permanente P.C. Ret. Plan & Trust*, 258 F.3d 986, 993 (9th Cir. 2001), *overruled on other grounds, Abatie v. Alta Health & life Ins. Co.*, 458 F.3d 955 (9th Cir. 2006). The Ninth Circuit has explained that "[a]n order remanding a case to an [ERISA plan administrator] is appealable only when: (1) the district court order conclusively resolve[d] a separable legal issue; (2) the remand order forces the

[plan] to apply a potentially erroneous rule which may result in a wasted proceeding; and (3) review would, as a practical matter, be foreclosed if an immediate appeal were unavailable." *Id.* (internal quotation marks omitted) (third alteration in original). This test both strongly resembles and has its origins in the collateral-order doctrine. *See Borntrager*, 425 F.3d at 1091-92. In applying this variant of the collateral-order doctrine, the Ninth Circuit has found ERISA remand orders to be final (and hence appealable) in some but not all cases.[3]

The Tenth Circuit likewise decides the finality of ERISA remand orders "on a case-by-case basis," *Rekstad*, 238 F.3d at 1263, finding appellate jurisdiction where review of the order is necessary to ensure that the court of appeals will have an opportunity to resolve "important legal questions which a remand order may make 'effectively unreviewable.'" *See* Pet. App. at 12a (quoting *Rekstad*, 238 F.3d at 1262). Appellate jurisdiction will lie only "when the issue presented is urgent" and when "the danger of injustice due to delay outweighs the inconvenience and costs of piecemeal review." *Id.* (internal citations and quotation marks omitted). The Tenth Circuit has yet to find an ERISA remand order that qualifies as final under its test.[4]

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[3] *Compare Banuelos v. Constr. Laborers' Trust Funds*, 382 F.3d 897, 903 (9th Cir. 2004) (jurisdiction), *Schikore v. BankAmerica Supplemental Ret. Plan*, 269 F.3d 956, 959 n.1 (9th Cir. 2001) (same), *and Hensley*, 258 F.3d at 994 (same), *with Fisher v. Aetna Life Ins. Co.*, 184 F. App'x 609, 610 (9th Cir. 2006) (mem.) (no jurisdiction), *and Williamson v. UNUM Life Ins. Co. of Am.*, 160 F.3d 1247, 1251-52 (9th Cir. 1998) (same).

[4] *See* Pet. App. at 15a; *Garner v. US West Disability Plan*, 506 F.3d 957, 960 (10th Cir. 2007); *Metzger v. UNUM Life Ins. Co. of*

In sum, despite differences in nomenclature, most courts of appeals take a similar approach to deciding the finality of ERISA remand orders. These circuits hold that, because remand orders leave more to do than simply execute the judgment, the orders qualify as final only if they satisfy the "stringent" requirements of the collateral-order doctrine or a close analogue thereto.

B. Petitioner Mischaracterizes The Controlling Law In At Least Three Circuits.

Petitioner seizes upon the slight differences described above in insisting that the district court's remand order in this case would have been appealable in the First, Fourth, and Ninth Circuits. Pet. at 33. This is plainly incorrect.

To begin with, petitioner confuses the appealability of a remand order with the standard of review that appellate courts apply in assessing challenges to a district court's choice of remedy. Pet. at 17-23 (quoting *Cook v. Liberty Life Assur. Co. of Boston*, 320 F.3d 11 (1st Cir. 2003), and *Grosz-Salomon v. Paul Revere Life Ins. Co.*, 237 F.3d 1154 (9th Cir. 2001)). There was no question in either *Cook* or *Grosz-Salomon* that the respective district court orders vacating the plan's decisions and retroactively awarding benefits were final and appealable. Those cases decided only that appellate courts "review[] a district court's choice of remedy for an ERISA violation" under the abuse-of-discretion standard. *See Cook*, 320 F.3d at 24; *Grosz-Salomon*, 237 F.3d at 1163. But abuse-of-discretion review is available only where the court of appeals otherwise has jurisdiction

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Am., 476 F.3d 1161, 1165 (10th Cir. 2007); *Rekstad*, 238 F.3d at 1263.

over a challenged order—a point that was neither contested nor raised in *Cook* or *Grosz-Salomon*.

Moreover, in quoting the *Cook* opinion out of context, petitioner overlooks the clear import of the First Circuit's controlling decision in *Petralia*, 114 F.3d at 354. As explained above, *Petralia* dictates that petitioner's appeal would be dismissed for lack of jurisdiction in the First Circuit. That court would treat the remand order as nonfinal and, because the decision to remand was intertwined with the merits of the benefits claim, would decline to exercise jurisdiction under the collateral-order doctrine. *Id.*

Petitioner also fails to cite any authority to support her contention that the Fourth Circuit would deem the challenged remand order final. Pet. at 33. This is likely because no such authority exists; the Fourth Circuit quite simply has not decided the issue.

Nor would the Ninth Circuit deem the remand order in this case appealable. While the district court's ruling that ERISA applied to the plan might constitute "'a separable legal issue'" eligible for review, *Hensley*, 258 F.3d at 993, it remains reviewable upon appeal from the final judgment entered by the district court following the proceedings on remand. *See id.* Petitioner can move to reopen her case or file an amended complaint in the district court if her benefits claim is denied on remand, and she can still "appeal the district court's decision that ERISA preempts her state law claim, and if successful, she will be able to pursue punitive damages." Pet. App. at 15a-16a. Review of the district court's resolution of that threshold issue is not "'foreclosed'" simply because petitioner must wait until after final judgment to contest the remand order. *See Hensley*, 258 F.3d at 993; Pet. App. at 16a. The Tenth Circuit therefore correctly concluded that

petitioner "would fare no better" in most other circuits. *Id.* at 17a. The lone exception, as that court recognized, is the Seventh Circuit. *Id.* at 19a-20a.

C. The Seventh Circuit Should Have The Opportunity To Reconsider Its Approach To The Finality Of ERISA Remand Orders.

In *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (1999), a divided panel of the Seventh Circuit held that a district court order finding error and remanding a benefits claim to an ERISA plan administrator constitutes a final order appealable under § 1291. The panel majority started from the premise that remands are justified in the ERISA context because a "plan makes the same kind of decisions as the Social Security Administration [SSA]." *Id.* at 978. The court then looked to this Court's decisions on the appealability of district court orders remanding claims to the SSA, which have focused on the language of 42 U.S.C. § 405(g). *Id.* This Court has held that, in a so-called "sentence four" remand, a district court enters a final, appealable order affirming, modifying, or reversing the SSA's decision. *Sullivan v. Finkelstein*, 496 U.S. 617, 625 (1990). That order can be appealed by either the claimaint or the SSA. *Forney v. Apfel*, 524 U.S. 266, 267 (1998). In contrast, a "sentence six" remand requires further evidentiary proceedings before the agency, is ordered before the district court has ruled on the propriety of the SSA's decision, and does not qualify as a final and appealable order. *See Finkelstein*, 496 U.S. at 626.

The *Perlman* majority attempted to draw a comparable line for ERISA cases. "If the district court finds that the [plan's] decision was erroneous and enters a judgment wrapping up the litigation,"

the court held, "that decision is appealable even if extra-judicial proceedings lie ahead; but if the court postpones adjudication until after additional evidence has been analyzed, then it has not made a final decision." 195 F.3d at 979. The same result would obtain, the court went on to observe, if the ERISA remand order were treated like an order remanding a claim to an arbitrator. *Id.* at 979-80.[5]

Judge Wood dissented on the merits and, although she agreed that the court had jurisdiction, strongly disagreed with the majority's reasoning on that point. The majority's analogy to the Social Security context, she wrote, was "tortured." *Id.* at 984. Not only are there important structural differences between the two settings, but the sentence four/sentence six line from the Social Security system "cannot be translated into an ERISA action." *Id.* at 985. This is largely because there is nothing in the ERISA field like a section-six remand; all ERISA remands occur *after* the district court has found some error—"either substantive or procedural"—in the plan's decision. *Id.* at 984-85.

The Seventh Circuit's minority—indeed, solitary—position does not warrant review of the decision in

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[5] The arbitration analogy rested in part on the view that this Court's decision in *Forney* "completed the process of making administrative remands generally appealable." 195 F.3d at 979. But *Forney* has not been read so broadly. *See Kreider Dairy Farms, Inc. v. Glickman*, 190 F.3d 113, 119 (3d Cir. 1999) ("[*Forney*] speaks only to appellate jurisdiction under statutes containing language comparable to that found in the Social Security Act"). Indeed, the prevailing rule has been and remains that orders remanding a matter to an administrative agency for further proceedings do not qualify as final. *E.g.*, *Pueblo of Sandia v. Babbit*, 231 F.3d 878 (D.C. Cir. 2000); *see also* 15B Wright, Miller & Cooper, *Federal Practice and Procedure* § 3914.32 & n.11 (2d ed. 1992 & Supp. 2007).

this case for several reasons. To begin with, *Perlman*'s limited jurisdictional holding has had only a limited impact in the Seventh Circuit itself. In the more than eight years since *Perlman* was decided, the Seventh Circuit appears to have relied on it only once in finding appellate jurisdiction over a district court's remand order in an ERISA case. *Davis v. Unum Life Ins. Co. of Am.*, 444 F.3d 569, 574 n.1 (7th Cir.), *cert. denied*, 127 S. Ct. 234 (2006). The limited effect of *Perlman*'s jurisdictional holding is further underscored by a series of decisions in which the Second Circuit has declined to decide the finality of ERISA remand orders. *See Giraldo v. Bldg. Serv. 32B-J Pension Fund*, 502 F.3d 200 (2d Cir. 2007) (per curiam); *Viglietta v. Metro. Life Ins. Co.*, 454 F.3d 378 (2d Cir. 2006) (per curiam). Resolving the question as a general matter was unnecessary, the court reasoned in each case, because the remand order at issue would not be appealable under *any* of the existing tests—including the one employed by the Seventh Circuit. *Giraldo*, 502 F.3d at 202; *Viglietta*, 454 F.3d at 379.

Furthermore, no other court of appeals has agreed with the Seventh Circuit's jurisdictional ruling or endorsed the analogies on which that ruling rests. Since *Perlman*, three courts of appeals—the Sixth, Eighth, and Tenth Circuits—have addressed the jurisdictional question as one of first impression. *Borntrager*, 425 F.3d at 1090; *Bowers*, 365 F.3d at 536; *Rekstad*, 238 F.3d at 1262; *see also* Pet. App. at 20a-21a. All three of these courts have expressly noted the Seventh Circuit's *Perlman* decision. All three of them have expressly rejected the conclusion reached in that case. Two of those courts predicated their rejection of *Perlman* on what Judge Wood pointed out in her dissenting opinion—that the

Perlman majority's analogy to the Social Security context is untenable in light of the specific statutory language that gave rise to this Court's decisions in *Finkelstein* and *Forney*. 195 F.3d at 984 (Wood, J., dissenting); *see Borntrager*, 425 F.3d at 1091 (calling the analogy "unsound"); *Bowers*, 365 F.3d at 538 (declining "to expand its jurisdiction by analogy").

Given *Perlman*'s limited impact even within the Seventh Circuit and the rejection of that decision by the other court of appeals that have considered it, the soundest course is to allow the Seventh Circuit the opportunity to reconsider its position in a future case. The fact that five regional circuits—the Second, Third, Fourth, Fifth, and District of Columbia—have yet to weigh in on the jurisdictional question renders that course all the more advisable and counsels strongly against immediate review by this Court.

II. THIS CASE IS A POOR VEHICLE FOR ADDRESSING THE QUESTION PRESENTED.

Even if the question presented were worthy of the Court's attention, this case suffers from a number of infirmities that weigh decisively against review.

First, petitioner asks this Court to decide the appealability of ERISA remand orders in a suit that—according to petitioner—is not even subject to ERISA. ERISA's applicability was the threshold issue litigated in the district court. Sup. Pet. App. at 42a. That issue was the focus of petitioner's efforts, since its resolution determined whether petitioner could proceed with her state-law claims and thus whether compensatory and punitive damages could be available to her. Pet. App. at 16a n.6. But after the district court ruled that ERISA applied, petitioner did not seek to certify that decision for

interlocutory appeal under 28 U.S.C. § 1292(b). As the court of appeals noted, petitioner instead "acquiesced to the district court's conversion of the suit to one stating an ERISA claim." *Id.* at 10a n.2.[6] This Court should not expend its resources to resolve a minor (and potentially self-correcting) conflict that is unique to ERISA at the behest of a litigant who seeks to invoke appellate jurisdiction to assert that the statute upon which that jurisdiction is grounded is inapplicable. This is particularly true where petitioner did not even try to establish ERISA's inapplicability through an interlocutory review mechanism far less extraordinary than a writ of certiorari.

Second, further proceedings would almost certainly be required in the district court regardless of how this Court resolved the jurisdictional question. Neither the district court nor the court of appeals determined whether petitioner was actually entitled to benefits. At the very least, therefore, the district court would be required to address this issue, and another appeal by either party could result. In addition, because the court of appeals vacated the district court order denying petitioner's motion for attorney fees, petitioner would have to reapply for fees in the district court following *either* the remand proceedings before the plan *or*, should this Court reverse the

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[6] It is no answer to say, as petitioner does, that the district court's order was interlocutory in nature. Pet. at 2. Section 1292(b) expressly governs orders that are "not otherwise appealable." Nor would it necessarily have been futile to seek certification from the court of appeals, which has recently accepted § 1292(b) certifications to resolve important issues in ERISA cases. *See, e.g.*, *Millsap v. McDonnell Douglas Corp.*, 368 F.3d 1246, 1248 (10th Cir. 2004) (availability of backpay as remedy); *Kidneigh v. UNUM Life Ins. Co. of Am.*, 345 F.3d 1182, 1183 (10th Cir. 2003) (preemption of state-law claims).

judgment below, an eventual remand from the Tenth Circuit.[7] Proceedings in the district court would only multiply, moreover, if petitioner prevailed before the Tenth Circuit on her principal argument that ERISA does not apply to her benefits plan. Resolution of the jurisdictional question, and in particular resolution of that question in petitioner's favor, will do little to hasten the disposition of this case.

Third, petitioner's focus on the supposedly invidious incentives produced by the court of appeals' ruling overlooks the crucial fact that the limits on appealing ERISA remand orders apply equally to plans and plan participants. At times claimaints feel aggrieved by a remand order and, as petitioner did here, seek appellate review. *See, e.g.*, Pet. App. at 2a; *Banuelos v. Constr. Laborers' Trust Funds*, 382 F.3d 897, 900 (9th Cir. 2004); *Petralia*, 114 F.3d at 353. In other instances, it is the plan that finds fault with the district court's decision and, realizing that it may have no other opportunity to vindicate its position in court, will attempt to take an appeal. *See Bowers*, 365 F.3d at 536; *Hensley*, 258 F.3d at 989; *Shannon*, 55 F.3d at 562. There are also situations where a remand order leaves both sides dissatisfied—the claimant because she wants an outright award of benefits and the plan because it seeks affirmance of its decision—and prompts both to appeal the ruling. *See Garner v. US West Disability Plan*, 506 F.3d 957, 959 (10th Cir. 2007); *Rekstad*, 238 F.3d at 1261; *Perlman*, 195 F.3d at 977. But courts have generally

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[7] The district court has already implemented the court of appeals' ruling by entering an order formally vacating its previous denial of the motion for attorney fees and dismissing petitioner's motion without prejudice to refiling. *Graham v. Hartford Life & Accident Ins. Co.*, No. 03-CV-0144-CVE-SAJ (N.D. Okla. Sept. 24, 2007) (Dkt. #56).

found the challenged orders to be nonfinal without regard to the identity of the appealing party or to the fact that both parties sought review. The prevailing rule, in short, cuts both ways.

Finally, petitioner's repeated references to the delay caused by her inability to take an immedaite appeal ring hollow. *See* Pet. at 5, 33, 36. Had petitioner allowed the remand to proceed before the plan, she may well have already received the benefits to which she believes she is entitled. Any additional delay in receiving those benefits is attributable principally (if not exclusively) to her decision to appeal the favorable remand order to the Tenth Circuit and now to seek review in this Court. This course of action reveals that petitioner is primarily interested not in long-term disability benefits, but in the compensatory and punitive damages that may be available under the state-law causes of action pled in her complaint. *See* Pet. App. at 16a n.6; Sup. Pet. App. at 47a-48a. Given these motives, there is no reason to credit petitioner's unsupported assertions that disability plans profit from "defer[ing] payments" to deserving claimants or that the remedy of remand somehow "encourages [the] wrongful denial" of benefits. Pet. at 5, 36. As the court of appeals correctly observed, the availability of attorney fees—of which "bad faith" on the part of the plan is a component, *see Gordon v. United States Steel Corp.*, 724 F.2d 106, 108-09 (10th Cir. 1983)—serves as a powerful check against unwarranted delays. Pet. App. at 17a & n.7.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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